Volume 3 Number 1

Winter, 1968

NORTH CAROLINA

JOURNAL OF MENTAL HEALTH

NORTH CAROLINA JOURNAL OF MENTAL HEALTH

Published by
The State Department of Mental Health
in conjunction with the
N. C. Neuropsychiatric Association

NORTH CAROLINA JOURNAL OF MENTAL HEALTH
is published quarterly, Spring, Summer, Fall and Winter.

It is a scientific journal directed to the professional disciplines engaged in care, treatment, and rehabilitation of mentally ill and retarded patients as well as to those engaged in professional research and preventive work in the field.

This journal is intended to be inclusive rather than exclusive and is not meant to be regarded as simply a house organ of the North Carolina State Department of Mental Health.

It is hoped that the journal will reflect the broad-based philosophy of psychiatry current and will draw on areas reflecting the total spectrum of psychiatric and neurologic thought, program and research.

Subscription may be obtained by writing the Editorial Offices, North Carolina Department of Mental Health, P. O. Box 9494, Raleigh, North Carolina 27603.

(Notice to contributors—see inner back cover)

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MENTAL HEALTH

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With this issue, the North Carolina Journal of Mental Health resumes publication after a hiatus of approximately one year, the last issue being Volume 2, Number 4, 1966. Hopefully, there will be no further interruption in publication of subsequent issues.

The Day Hospital as Part of a Community Mental Health Center

Overview *

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Two years ago I read a paper with a similar title at the annual meeting of the State Mental Health Authorities in the Atlanta Region. In re-reading the paper, I find that what I said then still holds true. For this reason I asked Dr. Clarkson, your program chairman, to distribute copies of the paper. What I say today will be based on two years of further experience with the mental health center program. I use the terms day care and partial hospitalization interchangeably in this paper.

Two years ago the National Institute of Mental Health had funded only a handful of center construction programs. In fact, the staffing regulations had not yet been promulgated. Developments have occurred in the interim. As of June 30, 1967, 191 construction applications and 132 staffing applications have been approved. The 250 centers (some received both staffing and construction grants) are serving areas containing 41 million people or close to 25 percent of the total population in this country. Except for South Dakota and Alaska, every state including Puerto Rico and the District of Columbia has received one or more grants. California leads the list followed by Pennsylvania, New York, Kentucky and Florida. North Carolina stands in the upper third of the list.

General hospitals received 94 grants, mental health clinics 75, mental hospitals 15, child care facilities eight, university training hospitals 13. Some 40 percent of the center applicants represented public facilities and 60 percent were private, nonprofit facilities. Eighteen percent were located in cities of a half a million or more, 36 percent were in cities of 50,000 to

**Based on a presentation given at a conference on "Day Hospitalization in Community Mental Health Centers", Statler-Hilton Inn, Durham, N. C., October 26, 1967.*

500,000 and about 45 percent were in cities of 50,000 or less.

The average population served by a center is 165,000 people. The average cost of operating a funded center is $775,000 a year. The average staff for a center includes four and one-half psychiatrists, three psychologists, seven and one-half social workers, eight registered nurses, two and one-half licensed practical nurses, 11½ aides and six rehabilitation people.

These are encouraging figures. It has been heartening to see the growing acceptance of the concept that mental health services should be delivered in a comprehensive, accessible and available program with continuity of care and preventive approaches. Rarely do we hear any question raised now about this method of providing care to people. However, the implementation of the new system of care and making it an actual reality is another matter.

During the past two years I have continued my visits to centers including some which have begun to operate under Federal grants. More recently I have been a member of a team from the Joint Information Service of the APA-NAMH which has undertaken a study of center programs under contract to NIMH. While the current visits have special reference to inpatient care, the entire center program is examined. My experience thus far leads me to conclude that the development of a center type program is a slow process, which needs to be accelerated.

I am very glad that partial hospitalization is the major topic for your meeting because its development is lagging. I think a major reason is the lack of familiarity of professional staff with this kind of program. Even in situations where professional staff have visited well-developed day care programs, their own partial hospitalization programs have not blossomed forth. The problem seems to me to be greatest in the voluntary general hospital.

On the whole, the best developed day care programs I have seen have been based in public facilities. This may be explained by the fact that public hospitals usually have mental health staff who are full time or serve part time on a fixed schedule. Also, because of the need for rapid inpatient bed turnover, partial hospitalization becomes essential. Patients from an overcrowded outpatient clinic may also utilize day care. Trained staff in an emergency room may develop greater skills in referring more appropriately to the various parts of

the mental health center program. Another consideration may be administration by a single agency other than affiliation of several agencies.

In contrast, voluntary hospitals, especially those under 300-400 beds, often do not have full time mental health staff. One psychiatrist may serve full time but usually other psychiatrists visit on fixed or non-fixed schedules. The number of social workers and psychologists in voluntary hospital programs is often smaller than in public hospital programs. Many voluntary hospitals, especially in medium sized cities and in rural areas, affiliate with community clinics. Often the two are physically separated, and sometimes at a distance from each other. While the clinic usually employs full time staff, particularly psychologists and social workers, liaison with the day care center based in the hospital may be limited.

I have begun to wonder whether it is possible to operate a center without an adequate corps of full time personnel. I am not yet ready to say that a full time psychiatrist is necessary but effective center program development and operation requires strong leadership and coordination by some full time personnel backed up by psychiatric clinical direction and responsibility. We need more experimentation and demonstration to show how privately practicing psychiatrists can fit day care for their private patients into the total scheme. In most centers, few private patients participate in day care programs. It seems hard to believe that finances alone determines clinical need. Privately practicing psychiatrists seem to make very little use of day care. My own observations lead me to think that lack of familiarity, understanding and knowledge of partial hospitalization is a major reason as well as difficulties related to payment and professional fees.

Often the patterns of hospitalization and other services reflect the boundaries of coverage. Insurance plans in many states do not cover partial hospitalization. However, an increasing number of plans are doing so. In North Dakota, for instance, Blue Cross will pay for 70 days of hospitalization and 140 days of partial hospitalization. This kind of insurance is the result of the work of professional people. Insurance carriers are likely to listen if it can be shown that partial hospitalization is more economical than full time hospitalization. Strong action by professional groups is needed.

Another important question is the physical placement of the day care program. I still maintain my earlier impression that placement depends on the local situation. The program may be placed in the hospital, either separately or in the inpatient unit, or it may be placed in the outpatient clinic or elsewhere. The size of the program and facility may determine which placement is best. However, some of my more recent visits indicate that when day care and inpatient care are placed together, day care tends to be slighted. The needs of the more acutely ill patients may absorb all the staff time or staff may prefer to work with the sicker patients. Also the day patients really have no base and the program seems amorphous.

My recent visits have also pointed up the need for a structured program. Structured programs have advantages for inpatients but I think they are mandatory for the operation of partial hospitalization. Therapeutic communities which are the basis of the program require structure. Otherwise patients do not have the opportunity for planned learning experiences and inter-personal exchanges.

The staffing of a day care program will depend in part on its physical location. If placed with the outpatient service, psychiatrists, social workers and psychologists will probably comprise the major part of the staff and nursing staff will be limited. If placed in the hospital, nursing staff will predominate. I have seen more day care programs of the latter type. Usually a nurse is in charge; however, the structure of the staff and the relationship of aides and nurses and other professionals is on a team basis rather than on a hierarchical basis. Decision making is shared among the staff and patients are also involved.

In my earlier paper, I described two methods of staff organization. A separate staff may be assigned to each element of service such as inpatient, outpatient or day care. Or a patient is assigned to a team which cares for him throughout his treatment career. An in between pattern has emerged more recently, particularly in large programs. Here the team structure is maintained and is placed physically either in a satellite in the community or if based in the hospital may be assigned to serve a sub-region of the catchment area. This team takes responsibility for emergency service during work hours, outpatient care, community consultation and all other

community activities, and maintains liaison with patients on inpatient or day care. A separate staff, mainly nursing service, is assigned to inpatient service assisted by a psychiatrist, one or two social workers and liaison members from the teams. A separate staff may also serve the day care unit or the inpatient and day care services may be combined. The success of this type of arrangement depends on adequate liaison between the community and hospital teams.

I might say a word about evaluation. So much effort has gone into establishing and developing the center programs that opportunity for evaluation has been limited. In addition, it takes time to develop a complete, strong program. However, some centers are undertaking evaluation and their first step relates to methods of recordkeeping. The old methods are not applicable in a multi-service setting where patients move in and out of the various elements. Several research projects are seeking ways to record patient data.

A systematic evaluation of day care in the Veterans Administration is reported in the book "The Day Treatment Center" by Meltzoff and Blumenthal, a Thomas publication in 1966. These two psychologists reported the findings of a three-year controlled evaluation of the day treatment center at the Veterans Administration regional office in Brooklyn. They hypothesized that day care would cut down the rate of re-hospitalization for chronic schizophrenics, provide a transitional experience between the hospital and the community for this patient group and help community adjustment. They based their hypothesis on the general principle that part time hospitalization would alter the environment of the patient therapeutically for part of the day, would break up and modify previous patterns of behavior, would allow for learning a new repertory of responses and would foster new adjustive responses to non-treatment settings. About 90 percent of their study and control patients were drawn from socioeconomic classes IV and V.

The investigators believed that self determination and patient responsibility were key concepts in day care. They limited the case load because of the need for a realistic, intimate and cohesive setting. Attendance in a daily day care session averaged about 50 patients. Activities consisted of regularly scheduled group activity, special scheduled events, informal

and spontaneous activity and individual activity. Paid work programs and vocational and pre-vocational assistance were provided.

The researchers found that staff needed a balance of aides, professionals, sexes, and skills. Staff roles were often blurred. The most important reason for failure of patients was related to the composition of the staff team, the lack of coordination and functioning of staff.

This carefully controlled study concluded that day treatment is effective in modifying the behavior of schizophrenic patients and inducing positive changes in adjustment. Thirty percent of the day patients in their program were re-hospitalized compared with 64 percent of a control group. They believe that day care can keep 70 percent of the patients in the community. Day care patients were able to hold their own, improve their adjustment in the community, improve in relation to their self attitudes, degree of understanding and in their relationships with family. However, there was not much change in the quality of inter-personal relationships or in patients' motivation.

The investigators concluded that day care is more economical and effective than usual outpatient treatment in forestalling hospitalization, modifying adjustment patterns and clinical states of marginal schizophrenics.

This book presents some encouraging findings in relation to chronic schizophrenics. However, it does represent a public program and a special group of patients.

I think our greatest challenge now in relation to day care is to find out how voluntary hospital-based comprehensive mental health centers can establish and carry out day care programs particularly with the involvement of the private sector of psychiatry. Experimentation, demonstration, and, most of all, inservice training for staff seem to be the essentials.

Clinical Pastoral Training in the Hospital— A Problem in Supervision

FRED W. REID, JR.

Assistant Professor of Hospital Administration and Hospital Chaplain

During the past few years theological education has seen something of a revolution in its efforts to train ministers more effectively to serve people. In this country theological education has had a long and interesting history in that the first colleges which were established had as one of their primary purposes the training of ministers. One author states, "The two cardinal principles of English Puritanism which most profoundly affected the social development of New England and the United States were not religious tenents, but educational ideals: a learned clergy, and a lettered people." (Morison: Harvard: Founding, p. 45). Thus, from the late seventeenth century to now we have been continuously faced with the ever growing problem of how best to train our clergy.

For the most part, theological education remained unchanged until the middle of the present century. Included in the aspiring minister's curriculum were rather heavy doses of Greek, Hebrew, church history, homilectics, archaeology, etc. without much attention being given to the human document itself. Theological training along with other forms of higher education in the United States had its common heritage in the European model which went back to the Greek philosophers for its source. In the early years of this country the only professional training which existed was for ministers. As soon as a young man could read and write Latin he could begin his training to be a clergyman. This concept of theological education continued in its classical vein on into recent times. However, within this century came men like Darwin, Freud, Marx and Engles—men who upset the equilibrium on the social scene. Theology along with other social, political and medical concerns could not and did not remain unchanged in the midst of revolution. In short, the church through its seminaries and educators has been forced to reexamine and take a second look at its curriculum in order to evaluate more accurately the *man* to whom the church minis-

ters. This reassessment has set into motion many interesting movements which are far from culmination. One such movement which has erupted onto the theological education scene is that of supervised clinical training for both the theological student and the trained minister who has come to recognize his own inadequacies in ministering to the needs of troubled people. Today there are many hospitals, penal institutions, business firms, etc. which have become the "clinical classrooms" for ministers desiring to know more about the human document and predictable behavior under certain circumstances.

One might well raise the question, "But what is different about this? The church has always talked about behavior in terms of sin, transgression, guilt grace and forgiveness." The church has indeed talked about human behavior and it has been the objective of the church to effect some change in human behavior. However, in the past the training which the seminarian has received in the classroom has not adequately equipped him to deal with the life situation problems which he immediately encounters in the parish. He finds himself in the position of having to minister to people who are experiencing hysterical grief reactions or critical illness and many times he is overwhelmed by this kind of intensive interpersonal relationship. He may have read about how necessary support is to some people or how meaningful the "human touch" can be to the bereaved but in essence this has not been a part of his experience and education. Now, in clinical training the minister can experience within a controlled environment the kinds of problems which will face him later in his professional work. Thus, we have established the reason and necessity for training men in the art of ministry before they are put in the position to be responsible for people's well-being. Now the question must be raised as to the "how" of this kind of clinical training.

It has become an accepted fact in the social sciences, in medicine, in psychiatry and other professions dealing with the problems of people that the practitioner must work within the context of his problem under supervision if he is going to gain any effectiveness in the practice of his profession. Thus, it seems that the essence of this problem of effectively training ministers lies in the idea of supervision. For a long

time it has been the practice of medicine, psychiatry, social service and others to supervise closely the work of their students as they gained some experience in their art. Clinical training for the minister represents this same endeavor and the results have been very gratifying.

In order to gain something of an historical perspective, we must go back to the nineteen twenties and there we find a Congregational minister by the name of Anton Boison who was a victim of illness himself. In the midst of this incapacitating experience he vividly recognized the need for ministers within the hospital setting. A little later in the mid-thirties a minister, Dr. Russell Dicks, and a medical doctor, Dr. Richard Cabot, collaborated in the writing of a book, "The Art of Ministering to the Sick", which meaningfully portrayed the effective relationship of physician and minister within the clinical setting. Throughout the forties and fifties this movement to orient ministers within the hospital gained momentum. Finally, it was realized that in order to really know what the problems of people were the minister had to experience with his people what they were experiencing and get the "feel" of what they were going through. At the same time it was recognized that unless the minister had some guidance in this clinical experience he would simply perpetuate his own inadequacies in attempting to work with these troubled people. Thus, there began the concept of supervised clinical training.

This method of educating theological students is occurring in various settings today but since the general hospital setting is the one most familiar to this writer, we will consider supervised training here.

Thus far, the theological students we have had in clinical training here at the North Carolina Memorial Hospital have been men who have completed their Bachelor of Divinity degree work and are interested in further professional training for the ministry.

Clinical training could well be described as a laboratory of interpersonal relationships. The applicants are screened in an effort to detect any traits of their personality which would not lend itself to the rather highly charged emotional atmosphere of working with troubled people. One aspect of the initial interview involves the task of trying to ascertain whether the applicant is "running from the church" or is attracted to additional training in order to further his the-

ological education. It is decidedly important that the minister is coming into this program seeking to have a therapeutic experience rather than to obtain assistance for his own personal problems. This training is predicated on the assumption that the trainee has a degree of emotional readiness to be receptive to professional training as opposed to the need for personal therapy. This is certainly not to say that the student should not bring his personal being into the training experience for this is an inevitable involvement which results in this laboratory of interpersonal relationships. He can only minister to persons out of the experience which he has had and is having under supervision.

Clinical training has drawn heavily from the social sciences, social service and psychiatry to construct its model for training. All of these disciplines put a great deal of emphasis on the case history method of approaching and understanding the person. Clinical training for the theological student introduces him to this approach in order that he might see the person functioning in the multiplicity of areas which go to make up his total existence. This is based on the premise that you cannot minister to a person unless you have a functioning idea of what makes him the person he is.

From the moment the student begins his period of training to the end of his clinical year in the hospital he is carefully supervised in all that he does. This rather intensive year of study exposes the theological student to the various functions of the hospital as a "caring community". It introduces him to the peculiar and special functions of the professional staff in an effort to help him coordinate his work as a member of the healing team. Most of all, this identity of being a part of the hospital team places upon the minister the special responsibility of functioning responsibly from within rather than without.

Immediately the student is faced with the dual activity of participation within a training program and rendering service to the institution where he is serving. Certainly this does not imply a cumbersome dualism but rather reflects a creative tension with which the chaplain intern must deal. During the year of his study in the hospital setting he is required to participate in the training group which meets three times a week. This aspect of training majors on "feeling" rather than con-

tent. In this particular activity there is no planned agenda in that the chaplain supervisor leads the session in a rather nondirective manner, allowing and encouraging the group members to learn to express their feelings, both positive and negative, about what is currently going on in their own lives and work. Over the years it has been the writer's experience that most ministers try very hard to avoid having hostile feelings, even though they consistently experience these feelings and are not quite sure what to do with them. It generally comes as something of a surprise when a group member expresses some negative feeling to the supervisor and finds that this feeling is accepted and he is supported. At this point in the training of the chaplain intern he has for the first time in his life, as is the case many times, the opportunity to fully express himself and also the opportunity to observe clinically the expression of others to him. The result of this kind of activity is to be found in the ministry which is then carried out on the wards of the hospital. Efforts are systematically made to tie together the activity which occurs within the group and ministry on the floor of the hospital. The chaplain intern is required to write verbatims of his visits to patients in order that the supervisor and the group may respond to the interpersonal activity which occurred within that visit. Generally, this kind of supervisory experience for the chaplain intern presents some rather threatening feelings in that prior to this clinical experience no one has ever scrutinized his ministry in this way. Thus, another concern is created which finds its way back to the group for discussion.

In short, the group becomes a reflective mechanism allowing the student to see himself and his ministry as others perceive him. At this point the group also becomes a vital workshop of theology in that the student experiences on a horizontal level the theological concepts of grace, forgiveness, acceptance, support, etc. in ways which, many times, he had never experienced them before. As one might suppose it is difficult to be confronted with your shortcomings but at the same time it is supportive to know that the other persons can accept you for the whole person that you are. It seems to me that this is a kind of living grace.

Other aspects of the supervised experience in clinical training include weekly sessions with the chaplain supervisor.

Within this context the student can discuss any special problems he may be encountering with his work in the hospital or in his relationship with the supervisor. Here the intern is encouraged to assume the responsibility of dealing with the problem. The supervisor will attempt to help the student recognize and come to grips with his own personality. It becomes the responsibility of the supervisor to support, confront, prod, etc. the student concerning the method of his ministry but it is the responsibility of the student to act on any insight gained from this ongoing experience.

Last but certainly not least, the student in clinical training is exposed to the body of knowledge or the content of pastoral care as it has developed to date. He becomes aware of the basic elements of personality development, psychology, theology of pastoral care and general readings in the area of pastoral care. Most important for our consideration is the fact that this student has the opportunity to put into practice this body of material during his year of supervised clinical instruction.

Just within the past few years clinical pastoral training has evolved from the idea of a handful of educators to a nation-wide movement which presently effects the bulk of theological students in this country. Even as this article is being written there are movements afoot to consolidate the nation-wide accreditating agencies for Clinical Pastoral Training. If this consolidation becomes an accomplished fact, and it appears it will, this will present an even stronger bid for clinical training for the theological student.

A History of the North Carolina Neuropsychiatric Association and North Carolina District Branch of the American Psychiatric Association

North Carolina made no provision for the care of the mentally ill until after the first half of the nineteenth century. Even though all of her neighboring states established hospitals for the mentally ill before 1840, and Virginia as early as 1773, all that could be done for these unfortunate persons in North Carolina was to incarcerate them in jails and almshouses.

Dorothea Lynde Dix had conducted successful crusades for the better care of the mentally ill in several states to the north, and in 1848 she came to North Carolina. She spent some time in a careful study of the situation, and then presented her "Memorial" to the North Carolina Legislature in November, 1848. It read in part:

> "I come not to urge personal claims nor to seek individual benefits. I appear as the advocate of those who cannot plead their own cause. In the providence of God, I am the voice of the maniac whose piercing cries come from the dreary dungeons of your jails — penetrate not to your halls of legislature. I am the hope of the poor crazed beings who pine in the cells and stalls and cages of your poorhouses. I am the revelation of hundreds of wailing, suffering creatures, hidden in your private dwellings, and in pens and cabins — shut out, cut off from healing influences, from all mind-restoring cures."

Miss Dix's dramatic and truthful presentation brought no action for almost six years. After she had helped nurse the wife of Representative James C. Dobbins through a depression, this legislator made another eloquent plea before the General Assembly in 1854, and this resulted in almost unanimous vote to establish a hospital for the "insane" at Raleigh. This institution, now called the *Dorothea Dix Hospital,* was opened for patients in 1856.

Additional state hospitals for the mentally ill were opened in Goldsboro in 1880, in Morganton in 1883, and at Butner in 1948. In 1911 a state institution for the mentally retarded (the Caswell Training School) was established in Kinston,

and in the 1950's similar schools were established at Butner and Morganton.

Although North Carolina was one of the last Southern states to recognize responsibility for hospital care of the mentally ill, the North Carolina Mental Hygiene Society, organized in Raleigh on February 14, 1914, was the first such organization in the South, and the eighth in the nation. The establishment of the Mental Hygiene Society resulted from a Conference on Mental Hygiene, held in Raleigh from November 28 to December 3, 1913. This conference was conducted by the National Committee for Mental Hygiene in cooperation with the Medical Society of the State of North Carolina and the Wake County Medical Society. Among those taking part in the conference program were Dr. Adolph Myers, Dr. George H. Kirby, Dr. Paul Anderson, Dr. Albert Anderson, and others prominent in the field of mental health, including Mr. Clifford W. Beers, the founder of the mental hygiene movement.

The North Carolina Mental Hygiene Society held annual meetings with prominent speakers each year through 1917. Another annual meeting was held in 1921, but then the organization ceased to exist. The reasons for its demise cannot be found in historical documents, but it is known that a survey of the state was made by the National Committee for Mental Hygiene in 1920, and that their rather unflattering report was suppressed. It is also remembered that professional support of the organization was weakened by lack of enthusiasm on the part of some professionals, especially psychiatrists, about the role of laymen in the mental hygiene movement.

Psychiatry in North Carolina made a large stride forward with the organization of the Duke University School of Medicine in 1931. Dr. Wilburt C. Davison, dean and professor of pediatrics, and Dr. Frederic M. Hanes, professor of medicine, had definite interests in neurology and psychiatry. In 1932 Dr. Raymond S. Crispell was added to the faculty to teach psychiatry and neurology. These three men—Crispell, Davison and Hanes—initiated another survey of the state's needs in the field of mental health.

During 1934 the groundwork for this survey was laid by drafting a resolution for the 1935 General Assembly, and by petitioning the Rockefeller Foundation for supporting funds. The resolution was adopted on March 20, 1935, and the sur-

vey commission, appointed by the governor, consisted of Dr. Frederick M. Hanes (chairman), Dr. Raymond S. Crispell, Victor S. Bryant, Jr., Louis Graves, and E. McNeill Poteat, Jr. Dr. Lloyd J. Thompson, associate professor of psychiatry at Yale University, was chosen to direct the project, which was supported by a grant from the Rockefeller Foundation. The work of the survey, conducted from October 1, 1935 to October 1, 1936, was summarized in a report entitled "A Study of Mental Health in North Carolina", which was submitted to the governor in January, 1937.

Another significant and independent development occurred in 1932, when the first psychiatric outpatient clinic in North Carolina was established in Charlotte. This clinic, with special interest in children, was under the direction of Dr. Sylvia Allen and was supported by a board of leading citizens, including Dr. Allyn B. Choate, an internist. In 1934 this board organized the Charlotte Mental Hygiene Society, which became the nucleus of the second North Carolina Mental Hygiene Society, established in 1936. Since that time Charlotte has led the way in many mental health developments in North Carolina.

The North Carolina Neuropsychiatric Association

The organizational meeting of the North Carolina Neuropsychiatric Association (NCNPA) was held at the State Hospital in Raleigh on January 18, 1935. At that time there were only 28 physicians in the state who were working in the field of psychiatry, 17 of whom were on the staffs of the three state hospitals. Seven were employed in the state's four private psychiatric hospitals, and three were practicing in the community. Dr. Crispell was the only one engaged in teaching. Dr. Ernest Poate of Raleigh, who assembled the organizational meeting, invited various physicians in the state who were practicing psychiatry or neurology, or who had definite interest in these specialties. Officers elected at this meeting were Dr. Poate, president; Dr. John McCampbell, superintendent of the State Hospital at Morganton, vice-president; and Dr. Sylvia Allen, secretary-treasurer.

The minutes of the first meeting are not available, but it is safe to surmise that the few psychiatrists in the state at that time agreed that they must present a united front and provide leadership in the rapidly developing mental health

movement. It is known that a few members would have preferred to stand aloof within their hospital walls and wait for the tide to ebb, but the prevailing opinion was that the psychiatrists must step into the flowing tide.

The only requirement for membership in the North Carolina Neuropsychiatric Association was membership in the Medical Society of the State of North Carolina. This was in keeping with the policy of maintaining a close relationship with medicine in general. Among the internists who joined the NCNPA in its early days were Dr. Allyn B. Choate of Charlotte and Dr. Wingate M. Johnson of Winston-Salem.

Dr. Poate, the first president, died soon after the Association was organized, and Dr. McCampbell succeeded to the presidency.(*) Two more meetings were held in 1935, and at the fourth meeting in January, 1936, Dr. Raymond S. Crispell was elected president. Dr. Crispell, a member of the survey commission, arranged two additional meetings in 1936 in conjunction with the commission. At the annual meeting of the NCNPA in January, 1937 copies of the survey commission's report were at hand, and the discussion centered around ways of implementing the several recommendations contained in the report. These recommendations continued as the main topic for discussion in the next few meetings of the Association.

In May, 1936, Mr. Clifford W. Beers, founder and secretary of the National Committee for Mental Health, visited the state on the invitation of the survey commission. He addressed a large audience in Charlotte, and afterwards a group of interested citizens met at the home of Dr. Allyn B. Choate to organize the second North Carolina Mental Hygiene Society (later changed to the North Carolina Mental Health Association). Parenthetically, it is of interest that the second North Carolina Mental Hygiene Society was organized just sixteen months following the formation of the North Carolina Neuropsychiatric Association. Although members of the NCNPA did not participate in these organizational activities, they quickly backed the Mental Hygiene Society and played an important role in the formation of local chapters in Durham and Winston-Salem.

Apparently the NCNPA was more or less inactive during

**The presidents elected at subsequent meetings are listed in the Appendix.*

the years of World War II.(*) Dr. Malcolm D. Kemp, president from 1944 to 1945, remembers that a meeting of the Association was held at Duke Hospital in 1945. During Dr. Maurice H. Greenhill's term of office in 1946 the North Carolina Neuropsychiatric Association became an affiliate of the American Psychiatric Association. It was also through Dr. Greenhill's efforts that a Section on Neurology and Psychiatry in the Medical Society of the State of North Carolina was established in 1946.

The original Constitution and Bylaws of the NCNPA specified that there should be "at least two meetings of the Association each year, one of these to be held in conjunction with the Medical Society of the State of North Carolina Annual Meeting. The fall meeting is to be held during the last week of October." Since the Annual Meeting of the State Medical Society, usually held during the first week of May, often conflicted with the annual meeting of the APA, the fall meeting of the NCNPA became the principal one, and new officers were installed at that time. (Recently the installation of new officers has been changed to the beginning of the calendar year). At most of the fall meetings prominent guest speakers from outside the state have been invited. (See Appendix)

At this point developments in the three medical schools of the state following World War II should be mentioned. A Department of Psychiatry and Neurology was established at the Bowman Gray School of Medicine of Wake Forest College in July, 1946. Dr. Lloyd J. Thompson, who had directed the mental health survey in North Carolina ten years earlier, became professor of psychiatry and chairman of this new department. (Dr. Richard C. Proctor now holds this position). Early in 1947 Dr. Richard L. Masland, who later became director of the National Institute of Neurological Diseases and Blindness, joined the department as professor of neurology. When the two-year medical school of the University of North Carolina was expanded into a four-year school in 1951, Dr. George C. Ham became the professor of psychiatry and chairman of this newly created department. (Dr. John A. Ewing succeeded Dr. Ham in this position). In 1953 the Department of Psychiatry of Duke University was reorganized and ex-

**Unfortunately the minutes of the meetings prior to 1952 were lost in the mail, and the history recorded thus far was obtained from early members who are still active and from papers written by Dr. Crispell.*

panded, with Dr. Ewald W. Busse as chairman and professor of psychiatry.

Returning to NCNPA business, a new Constitution was adopted at the annual meeting on November 19, 1948, and amended in May, 1952. Article II of this Constitution specified that "The membership shall consist of psychiatrists, neurologists, neurosurgeons, and other physicians interested in the specialty of psychiatry." Provision was made for honorary membership, but the active members had to belong to the Medical Society of the State of North Carolina and/or to the American Psychiatric Association. Fifteen standing committees were established, among them the Executive Committee, composed of "the officers of the Association, two councilors, the chairmen of special and standing committees, as well as the chairmen of the Section of Neurology and Psychiatry of the North Carolina State Medical Association and the Mental Hygiene Committee of the State of North Carolina."

The "two councilors" were the delegate and the alternate delegate to the American Psychiatric Association. The Constitution specified that they were to be appointed by the president. Dr. Lloyd J. Thompson was the first delegate and served until 1963 when Dr. Hans Lowenbach was appointed to this position. Dr. John C. Grier was the alternate delegate until about 1960, when it became customary to name the president or the president-elect as the alternate delegate.

North Carolina District Branch of the American Psychiatric Association

When the first meeting of the Assembly of District Branches of the American Psychiatric Association was held in May, 1953, only 16 District Branches had been established. North Carolina, although an affiliate of the American Psychiatric Association, was not one of them. In 1955 a petition for District Branch status was rejected by the APA because the constitutional requirements for membership were "too inclusive". A committee appointed to solve the impasse recommended the formation of a separate North Carolina Branch of the national organization with a more restrictive constitution, at the same time retaining the old North Carolina Neuropsychiatric Association with its constitution. This recommendation was adopted, and the new constitution was accepted by the APA. On April 30, 1956, the North Carolina District Branch became a

member of the Assembly of District Branches.

The North Carolina Neuropsychiatric Association has continued to exist alongside the North Carolina District Branch of the APA, and the two groups meet jointly. The officers of the two organizations are the same, and the minutes of business meetings are recorded under the names of both organizations. Members of the NCNPA who are not members of the APA are affiliate members of the District Branch. The existence of two organizations so nearly identical has resulted in some understandable confusion. For obvious reasons, members as well as outsiders prefer the name of North Carolina Neuropsychiatric Association — abbreviated to NCNPA — to the more cumbersome title of North Carolina District Branch of the American Psychiatric Association.

In 1958, at the request of the APA, special committees were appointed to work with APA committees on (1) technical aspects of psychiatry, (2) professional standards of psychiatry, and (3) community aspects of psychiatry. These special committees have from time to time submitted valuable reports that have kept the District Branch abreast of needs and actions at both national and local levels.

On April 8, 1962, a special meeting of the District Branch was held, to review the report of the Joint Commission on Mental Illness and Health (JCMIH) and to formulate a "position statement" on this report. The statement adopted contained items of local importance as well as the observation that the JCMIH report did not include child psychiatry or much that was practical about preventive psychiatry. On the basis of this observation, the District Branch's Committee on Community Aspects of Psychiatry immediately formulated a statement on services for children, with emphasis on prevention. This material later became the basis for a joint report from the Medical Society of the State of North Carolina and the North Carolina Mental Health Association, entitled "Mental Health Services for Children". This report was widely distributed in 1965. So far as is known, this was the first cooperative and comprehensive report by a state medical society and a state mental health association concerned solely with the improvement of mental health of children within its boundaries.

One of the most active committees of the NCNPA and the District Branch has been the Committee on Clinical Psy-

chology, which for several years strenuously opposed the efforts of psychologists to have laws pertaining to licensure or certification of psychologists passed by the General Assembly. The Medical Society of the State of North Carolina took the same stand. However, both groups urged the psychologists to adopt certification within their own profession, to eliminate unqualified practitioners from their ranks. Opposition to laws for state licensure ceased in 1966 when it was agreed that the state licensure of psychologists would provide protective standards and prohibit the unqualified from using the title "psychologists." With the approval of the NCNPA and the Medical Society of the State of North Carolina, the General Assembly passed an act known as "Practicing Psychologists Licensing Act" in 1967.

Starting in 1960 the District Branch took a definite stand in favor of the establishment of a state department of mental health, on a level with the departments of health, welfare and education. Such a department was established in 1963, and Dr. Eugene A. Hargrove was made Commissioner of Mental Health. This new department replaced the State Hospitals Board of Control, which had been concerned only with the mental hospitals and the schools for the retarded. All mental health clinics receiving state and federal funds had been under the supervision of the State Board of Health, which had been designated as the "Mental Health Authority" of the State. In 1963 the North Carolina Department of Mental Health became the "Mental Health Authority" and assumed responsibility for the local clinics.

Starting in June, 1963 and extending into 1965, a comprehensive mental health planning study was carried out. The main intent of the planning was to provide a state-wide network of facilities, services and programs at or near the community level. Twenty-seven state organizations participated in the study. The North Carolina Mental Health Council was the agency for the execution of long range planning, although much of the work was carried out through the offices of the Department of Mental Health. Dr. Harvey L. Smith was director of the study.

In 1961 the North Carolina Neuropsychiatric Association and the District Branch began the publication of a newsletter, edited by Dr. Hargrove. This newsletter was issued four times a year until the spring of 1965, when Dr. Hargrove

began publication of the *North Carolina Journal of Mental Health*. Since then all news items about the District Branch have appeared in this journal, which is also published quarterly. The purpose of the journal, as stated in the first issue, is as follows:

> "It is a scientific journal directed to the professional disciplines engaged in the care, treatment and rehabilitation of the mentally ill and retarded patients, as well as to those engaged in professional research and preventive work in this field. This journal is intended to be inclusive rather than exclusive and it is not meant to be regarded simply as a house organ of the North Carolina State Department of Mental Health."

The Association or the District Branch has representatives on the North Carolina Mental Health Council and the North Carolina Health Council. Many members have served as officers or committee chairmen in the Medical Society of the State of North Carolina, the North Carolina Mental Health Association, and the North Carolina Mental Health Council. Many others have served on boards of local organizations concerned with mental health. Practically all members of the recently formed North Carolina Council of Child Psychiatry belong to the District Branch, and a few in this group belong to the American Academy of Child Psychiatry. Nationally, many District Branch members have been committee chairmen in the American Psychiatric Association, and Dr. Ewald W. Busse was vice-president of the APA in 1966-67. Also, North Carolina has been well represented in the Group for the Advancement of Psychiatry (GAP). Several members have served and are serving on national advisory boards.

In the thirty years from 1936 to 1966, the membership of the North Carolina Neuropsychiatric Association has grown from approximately 28 to 134.

HISTORY COMMITTEE:
Robert L. Garrard, M.D., Chairman
Hans Lowenbach, M.D.
Richard C. Proctor, M.D.
Thomas H. Wright, M.D.
Lloyd J. Thompson, M.D., Secretary-Historian

October 1, 1967

Appendix

PRESIDENTS
of
NORTH CAROLINA NEUROPSYCHIATRIC ASSOCIATION
and
NORTH CAROLINA DISTRICT BRANCH OF THE AMERICAN PSYCHIATRIC ASSOCIATION

Year	*President*	*Visiting Speakers at Annual Meetings*
1935	Dr. Ernest Poate Dr. John McCampbell	
1936	Dr. Raymond S. Crispell	Howard R. Masters, M.D. Joseph R. Blalock, M.D.
1937	Dr. Julian W. Ashby	David C. Wilson, M.D. Lewis B. Hill, M.D. S. Spafford Ackerly, M.D. James K. Hall, M.D.
1938	Dr. James W. Vernon	Ralph P. Truitt, M.D. Bronson Crothers, M.D.
1939	Dr. W. D. Hall	C. J. Milling, M.D.
1940	Dr. Mark A. Griffin, Sr.	Kenneth E. Appel, M.D. Arthur P. Noyes, M.D.
1941	Dr. Mark A. Griffin, Sr.	Edward Stainbrook, M.D. Walter J. Freeman, M.D.
1942	Dr. Archibald A. Barron	Bernard Alpers, M.D.
1943	Dr. F. L. Whelpley	
1944	Dr. Malcolm D. Kemp	
1945	Dr. Malcolm D. Kemp	
1946	Dr. Maurice H. Greenhill	Clemens E. Benda, M.D.
1947	Dr. David A. Young	
1948	Dr. R. Burke Suitt	
1949	Dr. Lloyd J. Thompson	Robert H. Felix, M.D.
1950	Dr. John S. McKee, Jr.	
1951	Dr. George F. Sutherland	
1952	Dr. Robert L. Garrard	Lorant Forizs, M.D. James Asa Shield, M.D. Raymond S. Crispell, M.D. Paul Lemkau, M.D. Edward J. Stieglitz, M.D.

Year	*President*	*Out-of-Town Guest Speakers at Annual Meetings*
1953	Dr. Richard L. Masland	
1954	Dr. R. Charman Carroll	
1955	Dr. Thomas H. Wright, Jr.	Grete L. Bibring, M.D.
1956	Dr. George C. Ham	Jules H. Masserman, M.D. Joseph G. Kepecs, M.D.
1957	Dr. Ewald W. Busse	David C. Wilson, M.D. Daniel F. Blain, M.D.
1958	Dr. Angus C. Randolph	Manly Y. Brunt, Jr., M.D. Ian P. Stevenson, M.D. Howard D. Fabing, M.D.
1959	Dr. Walter A. Sikes	Harold F. Searles, M.D. Edward Evarts, M.D. Ives Hendrick, M.D. George E. Gardner, M.D.
1960	Dr. Marshall L. Fisher	Walter Riese, M.D. Maurice Natason, M.D. Jack Rubins, M.D. Antonia Wenkart, M.D. Erwin W. Straus, M.D.
1961	Dr. Eugene A. Hargrove	
1962	Dr. D. Wilfred Abse	Ian P. Stevenson, M.D. Harvey L. Smith, Ph.D.
1963	Dr. Hans Lovenbach	Roger W. Howell, M.D. William S. Allerton, M.D. Charles E. Smith, M.D.
1964	Dr. Mark A. Griffin, Jr.	
1965	Dr. Philip G. Nelson	Henry Weihofan, J.S.D.
1966	Dr. John A. Ewing	Francis J. Braceland, M.D.
1967	Dr. Charles R. Vernon	Jules V. Coleman, M.D. Abraham Wikler, M.D.

ORIGINAL MEMBERS OF
N. C. NEUROPSYCHIATRIC ASSOCIATION (1935)

Dr. William Allan, Charlotte, N. C.

Dr. Sylvia Allen, Charlotte, N. C.

Dr. Julian W. Ashby, State Hospital, Raleigh, N. C.

Dr. W. C. Ashworth

Dr. Archibald A. Barron, Charlotte, N. C.

Dr. Claude Boseman, Pinebluff Sanitarium, Pinebluff, N. C.

Dr. Allyn B. Choate, Charlotte, N. C.

Dr. Raymond S. Crispell, Duke Hospital, Durham, N. C.

Dr. Horace W. Frink, Chapel Hill, N. C.

Dr. Mark A. Griffin, Appalachian Hall, Asheville, N. C.

Dr. William R. Griffin, Appalachian Hall, Asheville, N. C.

Dr. Mabel E. Goudge, Durham, N. C.

Dr. W. D. Hall, State Hospital, Raleigh, N. C.

Dr. Frederic M. Hanes, Duke Hospital, Durham, N. C.

Dr. Wingate M. Johnson, Winston-Salem, N. C.

Dr. Malcolm D. Kemp, Pinebluff Sanitarium, Pinebluff, N. C.

Dr. Mike Lee, Caswell Training School, Kinston, N. C.

Dr. L. C. Liles, State Hospital, Raleigh, N. C.

Dr. W. C. Linville, State Hospital, Goldsboro, N. C.

Dr. Ira C. Long, State Hospital, Goldsboro, N. C.

Dr. Roy H. Long, State Hospital, Morganton, N. C.

Dr. John McCampbell, State Hospital, Morganton, N. C.

Dr. John S. McKee, Jr., State Hospital, Morganton, N. C.

Dr. John F. Owen, State Hospital, Raleigh, N. C.

Dr. A. S. Pendleton, State Hospital, Raleigh, N. C.

Dr. Ernest M. Poate, State Hospital, Raleigh, N. C.

Dr. F. M. Register, Caswell Training School, Kinston, N. C.

Dr. Augustus S. Rose, UNC, Chapel Hill, N. C.

Dr. E. H. E. Taylor, Broadoaks Sanitarium, Morganton, N. C.

Dr. Wesley E. Taylor, Greensboro, N. C.

Dr. Lloyd J. Thompson, Chapel Hill, N. C.

Dr. James W. Vernon, Broadoaks Sanitarium, Morganton, N. C.

Dr. F. B. Watkins, State Hospital, Raleigh, N. C.

Dr. Frank L. Whelpley, State Hospital, Goldsboro, N. C.

Dr. O. A. Young

A Community Work Therapy Program *

RALPH R. GARDNER, Ph.D.

Coordinator of Counseling
Veterans Administration Hospital
Salisbury, N. C.

I. *Background*

Community Work Therapy is a new approach at VA Hospital, Salisbury, developed by the Counseling Psychology Service to help selected mental patients prepare to re-establish themselves in the community.

A little background on mental hospitals and their patients will help clarify the need for such a service.

According to the Southern Regional Education Board (1), a survey of the 57 mental hospitals in 15 southern states indicated that they discharged nearly 57,000 patients in 1961; and as many as half of these return to the hospital.

VA Hospital, Salisbury has similar experience. This has been the only neuropsychiatric hospital in North Carolina operated by the Veterans Administration to serve eligible veterans. We have 1004 beds and have an average daily patient load of about 970**. Over one-third of our patients have been hospitalized over five years; somewhat less than one-third have been hospitalized one to five years; and somewhat over one-third up to one year. In fiscal year 1966 we discharged over 1,200 patients, an average turnover rate of nearly 11% per month. A like number were admitted, of which between one-third and one-half were readmissions.

You can see that we have long-term and short-term patients. These who are acquainted with mental hospitals are aware that patients whose hospitalization has been brief are relatively better able to resume normal relationships in the community—at work, in the church, school connections, recreational activities, social life, etc. Conversely, the long-term patient has lost contact with some or all of these.

But even this does not encompass his handicaps. Aside from the fact of advancing age, which itself brings "normal" deficits, the long-term patient—who has likely been psychotic—

**Presented in substantially this form to the Statewide Interagency Committee for Vocational Rehabilitation at Battery Park Hotel, Asheville, N. C., September 14, 1966.*

***As of January 1, 1966, 70 psychiatric beds were converted to medical and surgical.*

is apt to have become emotionally flat, unmotivated, uninterested, inept, slowed down, fatter, fearful, and isolated. It is difficult for the layman to appreciate the loss of sharpness which is almost inevitable in long-term hospitalization. We call this *institutionalization.*

Mental hospitals have many programs aimed at this problem. Activity therapies at our hospital—largely in PM&R—include occupational therapy, educational therapy, corrective therapy, recreation therapy, manual arts therapy, and physical therapy. There is, of course, an active Chaplain Service, in addition to psychotherapy, both individual and group. Many hospitals including our own have instituted patient government activities.

II. *Earlier Work Therapy Programs*

When I came to VA Hospital, Salisbury, we had the Member-Employee Program under which certain selected patients were placed on temporary Civil Service status and paid to work on assignments throughout the hospital. This was discontinued by law in 1963 and incentive therapy was substituted for the old Member-Employee Program. Under this program selected patients are paid a nominal hourly wage for work on assignments throughout the hospital. These programs are very good, but even the paid therapy programs do not seem to prepare an individual to return to the community. Perhaps they do not expect enough of patients. Somehow the assignments are not perceived as real life situations where the chips are down.

VA Hospital, Brockton, Massachusetts, has a highly publicized Community-Hospital-Industry Rehabilitation Program (CHIRP) (2) under which patients who can reach normal productivity get paid for a variety of production line industrial jobs performed in the hospital for which they are remunerated at substantially the going wage. In recent years they have transported a certain number of these patients to industrial plants where they work under a manual arts therapist from the hospital. This appears to have been an excellent program, and many patients are reported to have become regular employees of the industrial firms when they are discharged to the community.

Our Community Work Therapy Program allows patients greater freedom of action, greater freedom of choice, and demands greater self-responsibility. It is aimed largely at long-

term patients.

III. *Community Work Therapy*

On February 13, 1963 in a memorandum to the hospital director, a Community Work Therapy Program was proposed "to meet therapeutic and rehabilitative needs of selected patients whose successful treatment and eventual discharge to the community will be facilitated by work in the community . . . , strengthening his confidence in interpersonal relationships, cultivating good work habits in the competitive labor market, restoring old skills, learning new skills, reality testing with special reference to interests and aptitudes, introducing incentives and restoring employability." We not only took note of the values such a program might have to selected patients, but the public relations values involved in having the community participate in the restoration of mental patients. We anticipated educational benefits from the possibility of having community industries and enterprises better understand mental patients and their potential as employees. In a way community work therapy is an adaptation of the night hospital concept which includes features of and goes beyond many of the programs mentioned above. Since inauguration of the program we have extended it to include other competitive vocational activities such as formal training; and on occasion we have placed a patient on leave of absence to try out on a job in another city, discharging him after the arrangement has proved mutually satisfactory; and in still other cases, we have placed patients on trial visit to pursue employment or training so that they may continue to receive supportive visits by social workers, follow-up by Counseling Psychology, and medication while on trial visit.

We feel that it has been of value to have patients work under normal working conditions—with deductions for social security, Federal and State income tax, etc. just like fellow workers on the job.

While this program was approved in May 1963, it was operated as a pilot project until October 13, 1966 when (Salisbury VA) Hospital Memorandum No. 66-91 gave it official status.

IV. *Experience with Community Work Therapy*

The test of such a program lies in the way it accomplishes its purposes. The time element makes a definitive evaluation difficult and long, however. A preliminary evaluation has been based on the 14 patients who were on Community Work

Therapy in August, 1966.

These were predominantly long-term patients. Their average hospitalization in our facility totaled 76 months in September, 1967; and they worked in the community while under hospital treatment an average of 9.7 months.

Illustrative of these patients are the following cases:

1. A male patient started work on janitorial duties August 22, 1966 2 to 4 hours daily in a local restaurant at $1.25 per hour. He is service-connected from World War II for schizophrenic reaction and is rated at 100 percent disabled. He was admitted to our hospital December 1, 1953 and has been discharged from the hospital only 35 days since that time—in 1963. He was able to maintain a satisfactory level of work, and moved into a foster home in the community on trial visit status November 18, 1966; and at the end of September 1967 is making a good adjustment and is still working.

2. A female veteran of World War II was admitted to this hospital in December 1965 after a suicide attempt. She had no income and no money, and faced severe problems of adjustment when discharged because of the disintegration of her marriage. She was placed as a rose grader with a wholesale florist in June 1966 at $1 per hour. She continued to improve, and was discharged with maximum hospital benefits October 2, 1966, having saved enough money to make a new start. She has not been readmitted a year later.

3. This male veteran of World War II was admitted to this hospital seven times since April 1956. He was able to return home for only very brief periods. He received a small non-service-connected pension for schizophrenic reaction, his dependent mother getting a portion of this. His last discharge followed an elopement on March 13, 1966. He had been working—part time at first—as a dishwasher in a local restaurant from July 1965. After elopement he went to Washington, D. C. and secured employment at $2.95 per hour as an electrician's helper. He secured tranquilizer medication from a private physician and dressed his ulcerated leg each night in accordance with procedures followed at the hospital. His elopement and subsequent behavior was viewed with some satisfaction. When he returned home in May 1966 to pick up his clothing so that he could continue working in Washington, he was brought back to the VA Hospital by a deputy sheriff. He returned to his prior Community Work Therapy assignment in

a cafe in July and was discharged with maximum hospital benefits August 18, 1966 with plans to return to Washington, D. C. At the end of September 1967 he had not been readmitted.

4. This male veteran of World War II was transferred to VAH, Salisbury from a state hospital in June 1964. He receives a small nonservice-connected pension for schizophrenic reaction. He is an excellent bricklayer. He was placed on a Community Work Therapy assignment in November 1964 at $3 per hour, but this was discontinued in June 1965 when he had to be returned to a locked ward. In May 1966 he was placed in a similar assignment at $4 per hour and his progress during the past year on the program warranted a 90-days trial visit in the community in his own custody from which he was discharged with maximum hospital benefits September 13, 1967.

These cases are taken from the 14 cases on Community Work Therapy in August 1966. Twelve were rated for schizophrenic reaction, one was diagnosed chronic brain syndrome, and one was a depressive reaction. Only one—the depressive reaction—was hospitalized less than one year and that was for 10 months. One of the 14 quit after one week of work because he could not get along with his work supervisor; and he is the only one who might be considered a failure. A year later, seven of the 14 have been discharged "with maximum hospital benefits," two after a 90-days trial visit period. Three are out on trial visit status; one is on a 30-day leave of absence; one was discharged from elopement three months ago; and two are still hospitalized though still working in the community.

V. *Conclusion*

Nearly 100 patients have been on Community Work Therapy in four years. There are many success stories including a librarian who has been working in Atlanta now for two school years and a teacher in Rockingham County, North Carolina. Part of the credit for the success of this program should go to the local Veterans Employment representative who has worked closely with the Counseling Psychology Service in placing these people. The VA Regional Office and Division of Vocational Rehabilitation have lent us a hand with those cases who needed vocational rehabilitation prior to employment. We feel very grateful, of course, to employers in the vicinity

of Salisbury who have been willing to take mental patients; and many of them now contact the Counseling Service when they have an opening. The tight labor market of the last two years has been helpful, too. We undoubtedly have much to learn and we feel that even Community Work Therapy needs to be supplemented with other community services. We have ideas for a new program which will call upon additional community resources; for we do feel that the more supports a mental patient has in the community, the less will be the trauma of losing any one of them.

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(2) Winick, W., and Walsh, Francis X., "Community Hospital Industrial Rehabilitation Program," Mental Hospitals, March 1964, 147-150. See also *Mental Hospitals,* March 1965, 46.

*Roles and Functions of the Advisory Board**

HERBERT L. ROONEY, ACSW

Chief, Citizen Participation Branch
National Institute of Mental Health

During the early period of World War II, General Ira Eaker arrived in England as Chief of the Army Air Force Bomber Command. The citizens of the small community where the General was stationed decided to welcome him with a banquet. All the town's leading officials turned out, and there were many speeches given extolling the virtues of the Americans. Finally, there was a request for General Eaker to speak.

The General's words that night were: "Until we've done some fighting, I'm not going to do any talking. When we've gone, I hope you'll be glad we came."[1] General Eaker's brief remarks were received with a standing ovation by the audience.

We are gathered here today to do some talking. I would hope that by the day's end we will all be glad we came. For myself, I am delighted to have the opportunity to participate with you in this important conference. I congratulate those who are responsible for planning this meeting; I commend you for your presence here and for your involvement in mental health boards; I also extend through you my warm greetings to all other members of your boards.

Citizens Participation

While it would be presumptuous of me to point out to you the need for increased citizen participation in community mental health programs, it may be helpful in enlisting additional community interest to note the observations of Dr. John Gardner, Secretary of Health, Education, and Welfare, and Mr. Carl T. Rowan. In a recent newspaper article, Mr. Rowan addresses himself to citizen involvement. While mental health programs are not specifically the focus of the article, the inferences are clear:

"In Hillside, Mich., recently a young man asked me: 'Do you think the federal government will be able to devise some

**Based on a presentation given at the Eastern Mental Health Region Conference of Community Advisory Boards, East Carolina University, Greenville, North Carolina, October 20, 1967.*

program that will stop the rioting and fighting that we have had the last few summers?'

"The student and his question were typical of millions of Americans today. They are uneasy, deeply troubled, despite the fact that they enjoy wealth and other blessings never equaled in any other society; and they expect the federal government to wave some budgetary, or statutory wand, and erase their worries and troubles.

"Well, these Americans ought to read and ponder the speech given at the University of North Carolina by John Gardner, Secretary of Health Education and Welfare.

"Gardner articulated what seems to me the utterly plausible thesis that one of the major afflictions of our society is that people have lost a feeling of individual responsibility. Government is big and impersonal, and the average American has no real feeling that he controls to any degree the destiny of his society.

"Gardner gave an eloquent, solemn warning that the light will go out in the American dream unless we regenerate some sense of responsibility at the level of the individual, and of the local state government.

" 'To eradicate poverty, rebuild our central cities, lift our schools to a new level of quality and accomplish the other formidable tasks before us will require a great surge of citizen dedication,' the secretary said.

" 'If we imagine that the federal government alone, or federal, state and local governments alone can solve these problems, and that everyone else can stand by and play sidewalk superintendent, we are deceiving ourselves.'

" . . . we need to motivate people to the sense of responsibility and the spirit of selflessness required to do something about the social evils.

"The secretary really was appealing to Americans to grasp a broader vision of patriotism:

" 'We know that many are willing to die for their country,' he said. 'We also have to care enough to live for it. Enough to live less comfortably than one might in order to serve it. Enough to work with patience and fortitude to cure its afflictions. Enough to forego the joys of hating one another.'

"But Gardner himself observed that his was the voice of a segment of society where charity, humanitarianism, justice and abiding values count. For the secretary of HEW sees

'children being taught, the sick healed, the aged cared for, the crippled rehabilitated, the talented nurtured and developed, the mentally ill treated . . . . '

"There are some other values riding high in America today: power, money, technology, bigness, success.

"Gardner's speech left me wondering whether too many of us have clutched these latter values to our hearts and forgotten the old 'soft-hearted, sentimental' values of humanitarianism and justice."[2]

Another expression of citizen concern was voiced a few years ago by a young college student. This undergraduate had spent one summer working in a mental hospital. When his college program resumed in the fall, he recruited a number of his classmates as volunteers for the patients. The inspiring message of this young man to his fellow students as they prepared to enter the hospital's back wards was as follows:

" 'You are about to see the most shameful, the most wasteful thing in the country today. People who are sick and miserable just left to vegetate. Partly, no one knows what to do for them. Mostly, nobody is even trying. They lie on the floor or they sit. They don't do much else. Most of them don't even have shoes to wear, and many haven't been outdoors in years. Maybe it's not too late for some of them. Maybe we can help. But remember this: They are human beings, just like you and me. They have their hopes, aspirations, their fears. They're not monsters. They have their problems, just as you and I have, only theirs are magnified.

" 'You'll see them now. You'll smell the foul air they must breathe all day. You'll see the rotten chairs they use and the rags they wear. As citizens of this country, I want you to know that I hold each of you personally responsible for this thing.' "[3]

Thus, we see the appeal for citizen efforts in behalf of his fellow man stated from two different perspectives. Each statement has immediate relevance to the purposes which bring us together today in deliberations on advisory board contributions to community mental health programs.

Why Have a Board?

I have heard some people question the need for boards by referring to them as window dressing simply to satisfy legislative provisions. Others may say we have professional staff

to run our programs, so why is there need to have a board? Still others may question their ability to make meaningful contributions to a highly specialized program since they are untrained in mental health.

A review of some prime reasons for the existence of boards seems indicated both in response to the doubters and also in keeping with our conference objectives. You may determine in your discussions additional major reasons to have a board. As a beginning, here are a few reasons which occur to me:

A. *Program Permanency*

The creation of a board and the continuance of board structure, even though members may change due to a rotational policy, provide *program permanence and continuity.* This is a very pragmatic factor which must be considered. We must recognize that professional staff, however capable and dedicated to program goals, are transient; they will leave the program for factors related to retirement, illness, death, familial changes, other positions, etc. The board, then, represents that structure which will provide an enduring quality to the program and offer continuity in the midst of staff turnover.

B. *Community Interests*

The community at large is both a consumer and a supporter of mental health services. In mental health program design, direct services, (outpatient, inpatient, emergency, aftercare, etc.) are made available to consumers, and indirect services (consultation, education, preventive intervention, etc.) are also provided as integral elements of a total community plan. The citizen through voluntary or tax funds, in the last analysis, is the supporter of the program. The community, then, has a dual interest role in the mental health program as consumer and supporter.

Realistically, it is not possible for the entire community to manifest an active ongoing interest in the program. It is possible, however, for the community's interest to be *represented* on the board. In seeking to represent the interests of the total community, boards usually follow a pattern of representativeness which cuts across the various characteristics of the community. In the best fashion possible then, the board becomes an extension of the community representing the interests of consumer and supporter. The ensuing responsibility for each board member becomes,

indeed, a grave one and one which all too often is insufficiently stressed in orienting new members.

C. *Citizen Spokesman*

The very fact that the board is composed of community representatives enhances its ability to be an effective spokesman in behalf of the program. As citizens of the community the board can articulate needs and present budgets needed to secure resources to meet these needs. In so doing, the board is seen as the voice of the community by officials charged with fiscal responsibility. The mental health professional, on the other hand, is expected to seek budgetary increases by the very nature of his job. While the professional's involvement with the board in budget preparation is naturally to be assumed, the support and active participation of all board members in interpretation and presentation are vitally needed.

D. *Agent of Interpretation*

Boards often have been described as bridges between staff and community. Each board member is seen as an agent of interpretation in that he communicates in readily understood language to his family, friends, work associates, civic or voluntary organizations to which he belongs, etc., the purpose, nature and goals of the mental health program. In this role, then, each board member becomes a vital and necessary extension of the program reaching into segments of community life which the staff cannot directly reach.

A bridge, however, should provide access *into* the program as well as reaching out. The board by its knowledge and familiarity with particular aspects of community life, by its representative composition, and by its diverse geographic representation is also an agent of interpretation to the staff. This is a continuing process, for the board's sensitivity to community needs as a changing rather than static process, in turn, calls for frequently keeping staff apprised of these needs.

Some Characteristics of Boards

A. *Size*

Frequently, questions are raised concerning the optimum size of a board. In some instances, this will be prescribed by legislative provisions, but in the majority of cases the size of the board is determined in the original organizational by-laws with, of course, an allowance for

modification as indicated. Experience of various boards over the years would tend to indicate that initial size ranges from twelve to fifteen members. This size permits for a sufficiently wide representation from the community and at the same time remains a reasonable number for the involvement of all members in conducting the program. It is possible to increase the board membership as the program or organization increases in complexity and size. In many instances this stage becomes the appropriate time to implement the board membership with prestige names in the community who can contribute further to program advancement in such areas as fund raising and interpretation.

B. *Membership Term*

Usually, a board member is appointed for a three-year term. Since a rotating plan is desirable to permit for new ideas and diverse community representation, it becomes necessary for a newly organized board to appoint members for one, two, and three-year terms in order to build rotation into the board structure immediately.

While the merits of a rotating board far outweigh those of a self-perpetuating membership plan, consideration should be given to the reappointment of good board members who have served a full term, rotated off for a year, and thus are now eligible for another term.

A good technique to avoid confusion over length of terms as well as to convey purposefulness of board operation consists of a written notice to each member specifying his exact term of appointment. In addition, it is suggested that a total board roster listing terms for all members be prepared and distributed to the membership. This type of document becomes a very practical resource also in structuring various committees with members having varying lengths of board experience.

While it is important to consider the length of commitment for a board member, it is also imperative that the prospective member be advised in advance of his appointment of the precise expectations involved in this commitment. He should be advised, for example, that his attendance at board meetings is expected and informed as to the frequency of these meetings. He should also be apprised of the expectation that he will be serving on one or more board committees. Too often, in our zeal to attract people to boards

we tend to undercut the importance of their participation by glossing over such practical matters as frequency of meetings. Certainly, one criterion of a good board is attendance by its members at business meetings. It is far better that a prospective member decline to serve on the basis of inability to meet the minimum requirements than to fill up a board slot without appearing at meetings.

C. *Representation*

Since you already have some guidelines concerning the organizational representatives for the boards, I will only comment on general aspects of community representation. First, I would make a plea to have one or two young people (college age, for example) on the board to insure representation from that particular age group in order that needs and program ideas may be presented from the perspective of that important segment of the consumer community.

Ideally, a board should be representative of "all walks of life." While the mechanics for accomplishing this are sometimes rather difficult, it would be desirable to have as much diversity as possible. The most effective board representing a variety of community needs and interests is not necessarily synonymous with agreement by all members on all issues. Perhaps, in our desire to have a "comfortable" board we tend to concentrate on members from similar socioeconomic classes and on those whom we know will tend to agree on all matters. In so doing, we may remove ourselves from aspects of the community life which are most important to our planning.

Practical matters related to size of the total area covered by a board may make geographic representation virtually impossible. Where excessive distances, for example, may make regular attendance at meetings impossible, the plan for board extension into remote areas may be devised through creation of a small local committee. The chairman of the local committee would be designated as a board member, receive all communications regularly distributed to members, but would be charged with a fixed responsibility for studies, plans, involvement in program, etc., of his local community. He would be expected to keep in contact with the board through written and telephone communications but would be expected to attend board meetings only at certain prescribed times.

Patterns for selecting representatives from the commun-

ity seem to follow two main approaches. One approach to inviting a prospective board member is the *personal* one. The individual is recommended to serve due to the personal knowledge of a board member who knows this individual is supportive of the board's cause or is influential in the community. The other approach is the *organizational* one. In the latter, the board determines that certain organizations (medical society, school system, social agencies, voluntary organizations, etc.) should be represented and requests the organizational president or executive to designate a formal representative. The latter, then, is expected to fulfill a role of reporting back periodically to his organization the nature of the board's work. Advocates of this approach feel the various organizations are kept involved and informed, thereby extending the work of the board further into the community. Advocates of the personal approach feel there is greater assurance of selecting good board members based on prior knowledge of the individual.

A combination of both approaches may be necessary to achieve good board membership. In some instances, other organizations may require or, at least, prefer that a formal request be sent them to designate a representative to the board. Thus, a letter from the board chairman to his counterpart in organizations such as the medical society, PTA, etc., may serve not only to meet the customary procedures of these groups but may also implement the board's visibility among these significant community organizations.

The Board in Operation

A considerable amount of attention has been paid to the desirable attributes of the individual member and his contributions to the board. Less consideration has been devoted to those facets of board operation which will provide the necessary stimulus and framework calculated to encourage the active involvement of each member.

Perhaps we could think of the ideal board as one which blends a businesslike approach with that of an informal atmosphere which creates opportunities for each member's active participation. There is an orderly process in the conduct of the board's business which signifies the important nature of the operation. At the same time, there is a warmth in the style of the meetings which encourages lively discussion and interchange of ideas.

A. *Some Procedures*

The businesslike nature of the board should not be overlooked. While procedures should not be so ponderous as to restrict spontaneity at meetings, certain procedural steps should be written down in the by-laws or other documents which will serve as practical guidelines for officers and members. Among the first procedures should be a statement defining the frequency of board meetings. Lest this appear to some of you as an obvious fact, permit me to observe that some boards have operated almost primarily on the basis of informal contacts with the chairman without provision for board meetings.

Brief written descriptions of the duties assigned to officers are important elements in implementing board operation. These serve the purpose of communicating to the members that these roles are deemed sufficiently important to formalize in writing. Similarly, brief descriptions of standing committees should also be prepared since these are essential components of the structure designed to carry out the board's work.

Although most boards insure that regular minutes are kept, on some occasions there is a tendency to waive this procedure or disregard its importance. Excessive reporting in detail of all board discussions should not be encouraged. On the other hand, there should be provision for minutes which show topics discussed, board actions, summaries of committee reports, and members present. It must be remembered that minutes provide the only running record of the board's business, accomplishments, and items discussed. This type of recordkeeping may also be viewed as board acceptance of responsibility to the community which it represents.

In connection with recordkeeping and reporting, I would very much urge each board to consider the preparation of an annual report to be distributed in the community. This can be done in conjunction with a report of the mental health program or separately, as circumstances warrant. It is somewhat surprising, in view of the practical advantages inherent in such a communication vehicle, to note how often boards fail to take advantage of this.

B. *Committees*

Reactions to the suggested use of committee structure

run the gamut from groans of despair to gibes of derision. Notwithstanding these responses, the use of committees remains our most effective tool for involving members in the work of the board. The strategy, advocated by many, of giving each member a task is usually effected through committee assignment. As I reflect back over the years on my own experience in community work, the people who stand out in vivid memory are those with whom I was associated on various committees. Here were opportunities for close association with people in sharing common tasks. Here also were the joys, frustrations, and informal relationships emanating from a common experience. Here also was the reward of feeling the importance of contributing to the larger program entity.

Some boards distribute a questionnaire at the beginning of the board year to elicit the interest areas of the members. The questionnaire seeks expression of interest not only in terms of immediate committee assignment but also asks the members what they would like to do in assisting the board. This latter interest inventory may well provide helpful information for subsequent use on special tasks or additional committees. Since a board member volunteers his time, we may overlook the fact that the contribution *he* wishes to make may well be in a capacity far different from his daily occupation.

Since you are doubtless familiar with most of the committees utilized by various boards, I will list the most common ones and comment on only two. The list includes the following important committees:

By-Laws
Program
Nominating
Selection or Membership
Publicity
Budget
Fund Raising
Speakers
Hospitality

Depending on special needs of the board or the particular stage of program development, other committees may be supplemented or substituted to this listing. I would especially like to stress the importance of the Selection or Member-

ship Committee whose task it is to recommend new members to the board. This committee represents the first board contact for the prospective member and, accordingly, has the capacity for creating a positive or negative impression of the board. I further believe this committee should have a continuing responsibility after the newly elected member joins the board to insure that effective *orienting* materials and information are made available to the newcomer. The brief welcome given a new member is far from adequate to prepare him for meaningful participation in board discussions. *Orientation* of new members should be earmarked as a prime task.

I would also like to present an additional committee for your consideration. This is a liaison committee charged with identifying, developing, and maintaining relationships with other community agencies and organizations. Since all community organizations cannot be represented on the board it seems of paramount importance to extend knowledge of the board and the program into the community through a liaison role with as many community groups as possible.

As may be gathered, the roles and functions of boards are neither simple nor rigidly fixed. The live dynamic board makes demands on its members for persistence, ingenuity, and dedication. The tasks are frequently not easy, but those things in life really worth doing seldom are easy.

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(2) Rowan, Carl T., "Social Tasks and Sidewalk Superintendents." *The Evening Star,* Washington, D. C., October 13, 1967. Page A-17.

(3) Joint Commission on Mental Illness and Health. *Action for Mental Health.* New York, N. Y.: John Wiley & Sons, Inc., 1961. Page 90.

Book Reviews

Levinson, Daniel J. and Zaleznik, Abraham. *The Executive Role Constellation.* Boston: Harvard University Press. 1967 (530 pp)

The subtitle of this book is *An Analysis of Personality and Role Relations In Management.* This book lives up to all that is conveyed by both the title and the subtitle. Essentially, it delineates in some detail the workings of the three people comprising the top executive echelon in a mental hospital, and attempts further to develop a theoretical framework for analysis of executive groups generally. The book includes verbatim reporting of the transactions of the three psychiatrists-administrators, as well as their own observations of themselves and each other. They also provide their own analysis of the roles and the configuration of the constellation created by the three executives. The authors represent two independent research organizations, one at the Massachusetts Mental Health Center and the other at Harvard University. I recommend this book as excellent reading for anyone interested in our increasingly organizational society. It is a unique attempt to examine the structure and dynamics of management groups, and the influences of related sociopsychological forces upon the behavior, productivity, development and satisfaction of managers. Furthermore, through the use of a clinical method of investigation and interpreted case study, there is developed a role-analytic approach which analyzes the intermeshing of personal and organizational forces in determining what and how the organization in turn contributes to the individual's personal growth and development. The executive's organizational "roles" were considered to be the pattern behavior which resulted from the intermeshing of the personal and organizational forces. The "Executive Role Constellation" is considered to be made up of the structure of interlocking roles based on the specialization, differentiation and complementarity of the three constituent behavioral patterns.

The book is in six parts, with Part I outlining personal issues facing executives as members of organizations, and establishing the organizational context in which these three

executives worked. It also presents a general theoretical framework, and the theoretical approach used to analyze the behavior of the executives and their relations. Part II is a description of the individual roles of the superintendent, clinical director and the assistant superintendent as each conducted his work in the hospital. This part presents the concept of "role task."

Part III deals with the threesome as a group as they develop the executive role constellation. It begins with the initial steps arising out of the superintendent coming into the hospital as a new person and finding the assistant superintendent and clinical director already there, having worked with his predecessor, and prepared with various outlooks and expectations to greet the newcomer. This part discusses the development of the transactions that occurred and of the eventual interlocking set of behavioral patterns.

Part IV analyzes the actual functioning of the threesome during the period of the study as they relate to each other and also as they move through situations of varying interpersonal complexity.

Part V looks at some of the reciprocal effects between the executive role constellation and the middle management members of the organization, and considers two critical episodes, with responses of the subordinates to parts of the constellation.

Part VI summarizes the findings and interpretations of this study, and considers the methods used as to the sociopsychological forces contributing to effectiveness and ineffectiveness in top management groups.

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Ewalt, Patricia L. (Ed.) *Mental Health Volunteers: The Expanding Role of the Volunteer in Hospital and Community Mental Health Services.* Springfield, Illinois: Charles C. Thomas, 1967 (160 pp).

This book, a summary of a conference sponsored by the

Massachusetts Association for Mental Health (1965), deals with the role of sub-professionals as therapeutic agents. This venture in community psychiatry was attended by 250 people (60% volunteers, 40% professionals.)

The book is a series of papers presented by various individuals on the use of volunteers, high school, college, unemployed professionals, retired individuals, etc., in three types of contexts: (1) *hospital wards*—where they are used as aides in recreation, occupational therapy, case aides (Social Service) and as rehabilitation aides: (2) *transitional facilities*—such as day hospitals, night hospitals, etc.; and (3) *community resettlement*—foster family placement, nursing homes, social clubs, etc.

Emphasis is placed on the services of local mental health societies (lay membership) and the general observation that citizen volunteers readily become better spokesmen and educators generally than most professionals. It was suggested that well informed volunteers are potent forces in changing community attitudes since they have impact in many areas (job, school, etc.) remote from their contact with patients as volunteers.

In Indiana 4,500 volunteer "generalists" were asked to adopt a patient and do anything possible on behalf of patients. Generalists helped patients shop, ran motor pools, baby-sat, found and established apartments, helped patients meet merchants, find employers and gave directions to welfare, rehabilitation and other programs.

Six paid workers, commuters from the area mental hospital, in the Woodlawn area of Chicago, organized about 60 volunteers in each neighborhood and these, in turn, served as block leaders (pp. 10-11).

Some community mental health centers have employed full-time professional workers, typically social workers, to supervise volunteer services, establish orientation courses, select and recruit volunteers for (1) *indirect services*—typing, filing, bookkeeping, waiting-room assistants; and (2) *direct services*—(by referral) motor pool, tutorial assistance, cultural enrichment. (pp. 12-17).

The (Massachusetts) *Commonwealth Service Corps,* a domestic peace corps which became operational in 1964, recruits and places "paid" volunteers in social welfare agencies. It is funded by state government and workers are trained in host

agencies. About 10% of Service Corps programs are devoted to mental health facilities such as hospitals, clinics, and schools for the retarded. (pp. 18-23). The Boston State Hospital used 12 VISTA volunteers. An interesting feature of their program was a weekly group therapy session with a staff psychiatrist. It was suggested that such weekly sessions should become a routine part of all volunteer programs (pp. 52-59).

Hunt, who toured several state hospitals in connection with improvement programs, noted five (5) basic changes:

1. A basic *humanizing of the atmosphere* (open ward, less stringent regulations, etc.)
2. *Introduction of the unit system* (geographic or simple rotation of patients without regard to geographic origin.)
3. *Focus on rehabilitation of chronic patients* (remotivation, intensive treatment, vocational rehabilitation, sheltered workshops.)
4. *Development of specialized programs for specialized groups* (children, alcoholics, geriatric patients, drug addicts.)
5. *Leadership in developing community treatment of mentally ill* (preadmission screening, partial hospitalization, halfway houses, operation of out-patient clinics for aftercare). (pp. 25-31).

Mental health associations have helped sponsor sheltered workshops in mental hospitals. One such venture was based on work performed by patients which was tax-exempt. It was, in fact, a small business under nonprofit auspices for the benefit of patients. They provided renumerative employment in a setting approximating normal industry as closely as possible. Thirty-two companies contracted for 40 different tasks (e.g. packaging, collating, reclaiming, assembling, sewing, making millinery and shoe trimming, wire bending, wiring and soldering electronic devices, and using simple power machines such as air presses.) In four (4) years of operation, 131 patients completed training. Seventy-seven were released from the hospital (59% discharge rate compared to 3% for similar chronic patients) and over half of the 59% were gainfully employed outside of the hospital. (pp. 65-72).

Where does conflict most usually arise in using volunteers? Five typical situations are suggested:

(1) Where the use of volunteers is new or relatively

radical in the local culture.

(2) Where volunteers enter territory of professionals whose authority and status is not firmly established.

(3) Where volunteers disregard the authority of established policies and regulative mechanisms of professionals.

(4) Where volunteers interfere with mechanisms of the *status quo* which are latently functional for status groups (e.g. volunteers locking horns with ward aides for more human and mature patient performance.)

(5) When new territory is being charted and new roles are being forged so that professional workers move into territory which nonprofessional groups consider theirs. (pp. 147-156).

The book presents many interesting case illustrations of actual patient involvement with volunteers (pp. 48-49, 58) around community adjustment and placement. One is strongly reminded of the need for supervision of volunteers but one is equally impressed with the value of volunteer services. Volunteer services continue to grow in importance not only for the direct value of the services but because of the fact that volunteer service acts as a career selection devise and enables the volunteer to further educate the community of the values, goals and limitations of professionals in mental health services.

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NEWS BRIEFS

N. C. MENTAL HEALTH ASSOCIATION

Mrs. J. B. Spilman notified the Executive Committee of the North Carolina Mental Health Association at a recent meeting that her plans were to retire as Executive Director of the Association on September 30, 1968.

Following her decision to retire on that date, the Executive Committee announced plans to request that Mrs. Spilman remain with the Association after that date as a special consultant to the Association.

Her retirement on September 30, 1968 will bring to an end an eleven-year era of leadership and direction which brought the North Carolina Mental Health Association from a little known organization to the number one spot of prominence among the state's citizen health organizations.

Mrs. Spilman joined the Association as Executive Director in March of 1957 when the organization was struggling to get started across the state.

She developed a financial foundation for the organization, recruited the necessary volunteer leadership, and began to organize local chapters.

As a result of this citizen's activity, the mental health effort has been brought to the main street of North Carolina, has resulted in the formation of the North Carolina Department of Mental Health, helped develop the community treatment program, and has made mental health the number one public health effort in the state.

A native of Chowan County, Mrs. Spilman held many important positions before accepting the job in mental health. She was the first Commissioner of the Employment Security Commission in North Carolina. She served for fourteen years as Assistant Business Manager of East Carolina University in Greenville.

She has been a school teacher and an active and successful business leader.

Active in the Baptist Church all her life, Mrs. Spilman has served on the General Board of the Baptist State Convention and has been active in the Woman's Club across the state as well as in many other civic and service activities.

The North Carolina Public Health Service Association honored her last year with a merit award for her service in the mental health effort.

C. Vernon, NCNPA President

N. C. NEUROPSYCHIATRIC ASSOCIATION AND DISTRICT BRANCH OF THE AMERICAN PSYCHIATRIC ASSOCIATION

Presidential Message*

The North Carolina Neuropsychiatric Association now has an historical account of itself, thanks to the diligence of Lloyd Thompson and Bob Garrard. I believe we have an account of our distinguished organization which will both make us proud, and prove its usefulness as an introduction for prospective and new members to the club.

An abstract of the history was written to be submitted to the Assembly for inclusion with histories of other district branches. A copy of this will be sent to you in case you were not at the annual meeting. Later, the full history will be published in the North Carolina Journal of Mental Health.

The annual meeting was an apparent success, scientifically and socially. On Friday Abe Wikler told us a weird variant of Huntington's chorea which he treated successfully with haloperidol. Why it helped was a mystery, or for that matter why he presented the case was a mystery. Maybe the message was simply that you never know in a hopeless case so anything's worth a try. After Dr. Wikler, Jules Coleman spent an hour knocking community psychiatry, traditional psychiatry, psychoanalysis and others, then left us with the wise word that things will change whether we in psychiatry like it or not—and I do not think he likes it.

On Saturday Dr. Wikler gave his working theoretical scheme on the initiation and perpetuation of drug addiction. This concept has great potential for practical application in the treatment and prevention of addiction—including alcoholism. Later Saturday morning both Drs. Wikler and Coleman discussed the future of psychiatry. These two found themselves divided into two camps, the traditional scientific (Wikler) and the humanistic (Coleman) and tried to start a fight, but the peace loving moderator refused to hear it and a lively discussion with the audience ensued instead.

Of particular interest to the group was the question of what

**Delivered at the fall meeting, Jack Tar Hotel, Durham, N. C. November, 1967*

resident psychiatrists "should" be taught. In discussing this another kind of division occurred. There were those who said the psychiatrist-trainee needed primarily to learn how to apply being a "real doctor" to being a psychiatrist, how to take responsibility for and treat individual patients. And then there were others who countered that psychiatrists must recognize the morbid and premorbid conditions of our culture and work with others to get to these tremendous family and community problems. In addition, there were those amongst us who agreed with both points of view: that the scope of concern encompasses concern for all mental problems whether primarily manifest in or attacked through the individual, the family, or the community; however, at what point or points one decides to devote his helping energies is ultimately a question of professional conscience since one cannot "do it all". However there still seem to be some of us who have a comfortable identification with God—which would be all right, wouldn't it, so long as it was a matter of working with and not replacing Him!?

All in all it was a good meeting. Many members who should have been there weren't, but perhaps we'll catch them next year in Charlotte with President, Paul Donner; President-elect, Dick Proctor; Vice-President, Mickey Vitols; Secretary, Nick Stratas; and Treasurer, Francis Kane.

NEWS NOTE

The President of the North Carolina Branch of the American Psychiatric Association received the following telegram recently and wants to pass its message on to members. It reads as follows:

"Urge you to do anything you can to help insure no APA member replies to questionnaire on psychological fitness of President. Mail to psychiatrists this week by Avant Garde Magazine in New York City. This questionnaire emanates from same source as Fact Magazine's 1964 questionnaire about Mr. Goldwater. Implications are manifest. Signed, Henry W. Brosin, M.D., President, APA."

Regardless of implications, although these are important, it would seem obvious that such request for long distance psychiatric consultation, or in this matter long distance answer to an oversimplified question, is beyond comment.

MEDICAL SOCIETY OF THE STATE OF NORTH CAROLINA

Contacto-Rama Project

The Committees on Mental Health and Medicine and Religion of the Medical Society of the State of North Carolina, along with the North Carolina Academy of General Practice and the North Carolina Neuropsychiatric Association, sponsor a project of continuing education for physicians on psychiatric topics in the area of general psychiatric education, alcoholism, mental retardation and children's services, and medicine and religion. A speakers' bureau is maintained on these topics and medical physicians—local, regional and state—may contact the Medical Society regarding a program. The project provides a limited honorarium for the speaker.

Since the fall of 1965 around 2,000 physicians have received the benefit of this project. There have been 29 programs held in 1967. There were 9 programs on alcoholism, 11 on general mental health education, 2 on mental retardation and children's services and 7 on medicine and religion. Ten of these programs were presented to hospital staffs around the state. Nineteen of the programs were held for county medical societies which, combined, have a membership of 761 physicians. All total, this would represent over 30 hours of postgraduate education for 1967.

Notice to Contributors

Manuscripts and editorial comments should be addressed to the Editor-in-Chief, N. C. Department of Mental Health, P. O. Box 9494, Raleigh, N. C. 27603.

Contributors need not be psychiatrists, neurologists or M.D.'s but should be involved in some aspects of program, whether clinical, educational, or research, pertinent to mental health or mental illness.

Manuscripts offered for publication should be submitted in the original, typed on bond paper and double spaced with 70 characters per line. Footnotes, bibliographical references, quotations, etc., should also be double spaced and the use of footnotes minimized.

References to books and journals should be numbered consecutively in a bibliography at the end in the order in which they appear in the manuscript. References should be limited to those used by the author in the preparation of the article and kept to a minimum.

The author's privilege of correcting galley proofs may apply only to printer's errors.

Tabular material, drawings and charts should be submitted on separate sheets, clearly marked as to where they are to appear in the text.

Vol. III, No. 2 1968

NORTH CAROLINA

JOURNAL OF MENTAL HEALTH

NORTH CAROLINA JOURNAL OF MENTAL HEALTH

Published by
The State Department of Mental Health
in conjunction with the
N. C. Neuropsychiatric Association

NORTH CAROLINA JOURNAL OF MENTAL HEALTH
is published quarterly, Spring, Summer, Fall and Winter.

It is a scientific journal directed to the professional disciplines engaged in care, treatment, and rehabilitation of mentally ill and retarded patients as well as to those engaged in professional research and preventive work in the field.

This journal is intended to be inclusive rather than exclusive and is not meant to be regarded as simply a house organ of the North Carolina State Department of Mental Health.

It is hoped that the journal will reflect the broad-based philosophy of psychiatry current and will draw on areas reflecting the total spectrum of psychiatric and neurologic thought, program and research.

Subscription may be obtained by writing the Editorial Offices, North Carolina Department of Mental Health, P. O. Box 9494, Raleigh, North Carolina 27603.

(Notice to contributors—see inner back cover)

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MENTAL HEALTH

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EDITORIAL

Autonomous or Participatory?

It is evident to those who have examined the literature and who have taken part in discussions regarding the geographic unit system that this "modus operandi" presents a unique paradox. The degree of successes and failures of this system are impressive and there seems to be no explanation as to why this paradox frequently coexists in the same institution.

In the majority of discussions and literature regarding the unit system, the word "autonomous" consistently recurs, for example, "The geographic unit is a small autonomous hospital within a larger hospital." Webster's definition of "autonomous" is "having the right or power of self-government, undertaken or carried on without outside control: self contained, existing or capable of existing independently."

Do we actually expect these units to be autonomous, or do we wish them to be participatory in nature? A participatory unit would encourage its personnel (both patiets and staff) to assume as much responsibility and authority as they could handle adequately. At the same time it would stimulate them to be continuously cognizant of the fact that they are also a part of a greater system of patient care—provided by other units and special services within the larger hospital setting, and by individual communities which the hospital unit serves.

The word "autonomous" leads us to think in terms of absolute independence. It follows, then, that an autonomous unit would divest itself from all other components of the total system of care. Too frequently this thinking visibly evidences itself in various ways and produces an unhealthy and isolated system of care that does not serve the best interest of our patients.

This may well be a small point regarding the geographic unit system but it is a point well worth considering. The history of the world has frequently been changed by seemingly insignificant occurrences because they have become the focus of the development of attitudes —both positive as well as negative. And attitudes can point the way to successes or failures.

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Physical Evaluation and Treatment of Alcoholics in N. C. Operated In-Patient Institutions: 1962-63 vs 1966-67

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During the 1950s and 1960s there has been a progressive increase in the percentage of alcoholics amongst first admissions to state mental hospitals (1-3). This general trend is paralleled in North Carolina. A comparison between the number of alcoholic admissions in the fiscal year 1962-63 with those admitted in 1966-67 shows an increase of 171%. In the fiscal year 1962-63 there were 1,707 alcoholics admitted (one out of every eight patients) whereas in the fiscal year 1966-67 no less than 4,624 admissions had an alcoholic diagnosis (one out of every three patients). Of all the diagnostic groups admitted to the N. C. State Hospitals, the alcoholics have the shorest average duration of hospitalization. In 1966-67 about one half of the alcoholic patients were released within 24 days.

Increasing numbers and the rapid turn over rate of this population results in an increasingly heavy burden being borne by both the clinical personnel and the auxiliary services of the hospitals. In considering the magnitude of statistical change in this population one might anticipate a quantitative decrease in clinical service given to the individual patient as regards evaluation and treatment. The aim of this study was directed at answering the question: "Did the alcoholic patient receive the same amount of service, as regards evaluation and treatment in 1966-67 as did his counterpart in 1962-63?"

Method

Patient Population: Alcoholics maybe clasified into one of three diagnostic categories: Acute brain syndrome associated with alcohol (02.1); Chronic brain syndrome associated with alcohol (13.0); or alcoholism addiction (52.3). As approximately 85% of first alcoholic admissions, in both the fiscal year's in question, were classified in the third category, namely alcoholism addiction, it was decided to select the study population from this diagnostic category.

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Using a table of random numbers a sample size of 129 alcoholic (52.3) admissions were selected from both fiscal years: 1962-63 and 1966-67. The sample contained alcoholic admissions in the same proportion as they were distributed in the four state mental hospitals and the Alcoholic Rehabilitation Center.

Data: A simple source document was designed which contained entry spaces for the following: (a) Laboratory investigation: chest x-ray, urinalysis, blood chemistry, hematology and Wassermann reaction: and (b) Psychiatric treatment: none, individual psychotherapy, educational therapy, family therapy, group psychotherapy, chemo-therapy, rehabilitation therapy, therapy through collateral and other therapy. It was considered that the above items would be reliable indices of physical evaluation and psychiatric treatment for quantitative comparison.

The data were abstracted from the medical records at the various institutions by two members of the staff of the Division of Statistics. Only data filed or noted in the patient's medical record were collected.

In addition to the above the following information was also received: (a) length of hospitalization for the admission under study; (b) date of readmission if applicable; and (c) "time in the community."

Results: Editing of the source documents showed that one patient in the 1962-63 group had been hospitalized for a period of eighteen months. Data on this patient were not included. Another six patients in the year 1962-63 were also not included as their medical records were not readily available. This left a sample size of 122 for 1962-63 and 129 for 1966-67.

The null hypothesis "no significant difference between 1962-63 and 1966-67" was adopted in comparing all items. Student's t-test was used to determine significance.

Table I — Statistical Significance and Percentage of Service and Treatment Received by Alcoholics in Fiscal Years 1962-63 and 1966-67.

Service and Treatment	Percentage 1962-63	1966-67	Significance (p4.05)
Laboratory			
Chest X-Ray	39.3	89.9	Significant
Uranalysis	96.7	96.9	Not Significant
Chemistry	36.9	51.9	Significant
Hematology	77.0	82.2	Not Significant
Wassermann	91.0	8.76	Not Significant

Treatment

Non—Not Treated	13.9	17.8	Not Significant
Individual Therapy	22.1	11.6	Significant
Educational Therapy	0	0	Not Significant
Family Therapy	0	0	Not Significant
Group Therapy	36.1	75.2	Significant
Chemo-Therapy	70.5	87.6	Significant
Rehabilitation Therapy	3.3	20.9	Significant
Therapy Through Collateral	0	0	Not Significant
Other Therapy	0.8	6.2	Significant

Table I shows the statistical findings in this study. The percentage in Table I reflects the number of patients who received a particular service divided by the total number in the sample for that particular fiscal year.

It can be seen that there was an increase in the percentage of all laboratory investigations except the Wassermann reaction from 1962-63 to 1966-67 and two of these differences are significant, namely: chest x-ray and blood chemistry.

In general, alcoholic patients received more psychiatric treatment in 1966-67 than those admitted in 1962-63. Significantly more patients were recipients of group, chemo, rehabilitation and other (occupational and recreational) therapy in 1966-67 than 1962-63. The only area in which there was a significant decrease of therapy in 1966-67 was in the sphere of individual psychotherapy. In three of the treatment categories, educational therapy, family therapy and therapy through collateral, none of the patients in either year had any of these treatments noted in their medical record. It is interesting to note that approximately 14 per cent in 1962-63 and 18 per cent in 1966-67 were not recorded as receiving any type of treatment. This may be associated with short periods of hospitalization.

Regarding duration of hospitalization, on the average alcoholic patients were hospitalized for 29.4 days in 1962-63 compared with 24.3 days in 1966-67. This drop of approximately six days was statistically reliable. Therefore one may conclude that patients in the earlier fiscal year remained in the hospital significantly longer than in the later fiscal year.

Comparison of the re-admission rates, within a period of six months of the original hospitalization, between these two popu-

lations showed that in 1962-63 slightly over 13 per cent returned within that period of time whereas in 1966-67 approximately 15 per cent returned. This difference was not statistically significant.

Discussion

The most outstanding conclusion of this study is the quantitative increase in service, both evaluatory and treatment, in the later fiscal year. This increase occurred despite the marked rise in the number of alcoholics admitted and a shorter duration of hospitalization. The causes of this increased service activity cannot be pin-pointed in this study but must reflect a general increase in the intensity of physical investigation and psychiatric care at the individual units concerned.

It is interesting to note that no positive association was found between the intensity of care and length of time in the community before re-hospitalization. As so many constitutional and cultural variables such as age, sex, race, marital educational and economic status have been associated with alcoholism (4-6) it is likely that prevention of alcoholism will be more in the field of community psychiatry than in the area of clinical hospital care. In fact if one were to take a Szaszian viewpoint (7) one might predict that better hospital care would motivate a desire for rehospitalization.

This study indicates that a significant shift occurred between two types of psychotherapy, individual and group, in the comparison of the two fiscal years. In the earlier year individual psychotherapy was predominant whereas in the later year greater emphasis was placed on group psychotherapy. This changing emphasis, from individual to group psychotherapy, was probably but not necessarily an adaptational response of the individual psychotherapists to the massive increase in alcoholic patient turnover. The time factor obviously limits the number of patients who can benefit from psychotherapy in the one-to-one situation, whereas group therapy extends this type treatment to larger numbers of recipients.

Summary

A comparison was made between random samples of alcoholic patients (52.3) admitted to the N. C. state alcoholic facilities in the fiscal years 1962-63 and 1966-67 as regards physical evaluation and psychiatric treatment. The following values were used as quantitative indices of these factors: chest x-ray, urinalysis, hematology, blood chemistry, Wassermann reaction, individual

psychotherapy, group psychotherapy, educational therapy, family therapy, chemo-therapy, rehabilitation therapy and therapy through collateral.

Despite a gross increase in the turnover rate in alcoholic patients significantly more of them received chest x-rays, blood chemistry, group therapy, chemo-therapy, rehabilitation and other type therapy in 1966-67 than in 1962-63.

On the average the alcoholic patients in 1966-67 stayed a significantly shorter period of time in the hospital than did their counterparts in 1962-63.

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The authors of this paper are gratefully indebted to Mrs. Mary Ball and Miss Julie Wheeler for their tireless efforts in collecting and processing date for this project. Also, our thanks to Mr. Hamilton Chang for performing the statistical tests.

*Relationship of In-Patient Programs to Developing Mental Health Centers**

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It is a well known ploy or gambit for speakers to start off by reminding audiences that they live in important, exciting, grave and crisis-ridden times. This is designed to focus attention on what comes afterward, giving the speaker the opportunity at least to prove that he has something to say which bears on these issues. I am no different. I employ the ploy!

Certainly, in our field of mental health and in all programs of social betterment, this is a time of tremendous change and pressure. Our old methods with which we may have been uneasily comfortable are being scrutinized, challenged, disparaged, judged and, in many instances, scornfully and patronizingly dismissed, by our friends as well as those who are just getting around to us. Among other things, this is a time of confusion and uncertainty not only for the militant ultra-conservative, but also the timid, the angry and the lazy. Similarly affected are those who greet the new day with starry-eyed joy, dreaming of magical solutions and Instant Mental Health. They are inexperienced in the waving of those wands which come free with that handsome gift-wrapped package called the Comprehensive Community Mental Health Center, and flounder when the right words and noble aspirations don't turn into beautiful programs.

Having described and identified this confusion in our lives, let me say that the 33rd Geigy lecturer does not come to you tonight as the Ajax White Knight who with one magnificent thrust will reveal to you "whiter than white, brighter than bright" the real and only truth, the last word, the panacea. In fact, I myself, as I travel, listen expectantly for the hoofbeats of Ajax' mighty steed: Should I discover him soon in my peregrinations I will, without asking permission of Dr. Riddle, Dr. Fowlkes or even Mr. Geigy, book him as the 34th or 40th lecturer. I'll be the fellow in the front row that night.

Your announcement flyer says I will talk about the relationship of inpatient programs to developing community mental health

*Presented at Western Carolina Center, Morganton, North Carolina as part of the Geigy Scientific Lecture Series. January 30, 1968.

centers. By this is meant, I suppose Broughton and New River at Boone, general hospital psychiatric units (where they exist!), and Centers that are dreamed of in Asheville and Morganton—those that are developing in Cullowhee and Charlotte. One is generally never happy with titles of speeches and papers and I have a quarrel with mine. The word "relationship" which is certainly an "in" word today has within it the seeds of separateness, a holding back from total commitment and the possibility that the programs and those who man them, may become more important than the citizens they serve. Please note I have used the word citizen rather than patient for that word is questionable also since it narrows our focus in community mental health and leads us to the frustration and pessimism which rises whenever we try to multiply number of patients times the 50 minutes in the traditional treatment hour.

Having made this point, I restore the word relationship in my title to good standing so as to discuss, if briefly, a few areas of problems and potentiality.

Some stereotypes! The state hospital.

Side I. It is mammoth, custodial, poorly staffed, revolving doors, locked doors, disinterested in its communities, angry at them! It only seeks to avoid trouble, organizes for its own convenience and robs its patients of their dignity and individuality. Its image is such that it can never become the center of comprehensive mental health services or have any effective relationship to such a center.

Side II. It cares more about its patients than do the families and the communities. It is used as a dumping ground. It is budget-starved. It is the drab step-sister, the whipping boy! The last home for the elderly, sick poor whose psychiatric disability is not their major problem! It is a mecca for ambitious reporters bent on the expose, or for those who wish to beat the drums for mental health for a while until the story loses its immediate news value.

Side III. (a triangle) It only needs more money and personnel to do the whole job better, and fie on the communities and their Centers which only wish to skim off the cream! It can do more for old people than inadequate community nursing homes and others who think "state hospital" when the patients' funds dry up! It is already providing comprehensive services!

The general hospital in-patient unit.

Side I. First of all, where are they? They're for the patients of private practitioners! Doctors' workshops. They're way stations to the state hospitals! They have no program and are staffed by people who wouldn't know one if they saw it. If anything, they are worse than state hospitals.

Side II. The general hospital speaks. Yes, we already admit psychiatric patients. Our doctors take care of everything! We don't need all those social workers, psychologists, etc. We have an occupational therapist. She has a loom. See the potholders we turn out! Aftercare, what's that? We also have an emergency room. We never turn anyone away! We see some alcoholics but don't solicit the business! We do have to send patients to state hospitals but isn't that what they're for?

Side III. Sure, we'll join your mental health center! We have some plans to build a psychiatric wing, and isn't this the way to go today? We'll sign all the agreements. Admit indigents— well if you say so and we must. Continuity of care, no problem. We see some outpatients now! Availability of records, likewise! Consultation and Education — whatever it is, we're for it. Our psychiatrists already consult on Surgery and Medicine, and Dr. X spoke to the PTA last week on Discipline in Home and School.

The Community Mental Health Center

Side I. We sure need a new building. (Usually the clinic speaks.) We're doing most of those required five things already! There's very little need for in-patient facilities for children in our area. We believe in prevention, but there's this waiting list in our clinic.

Side II. The State Hospital! How do they fit in here? We're going to do this job right here at home! No we haven't involved them in the planning. They're not "with" all this new religion. They're on their way out! Of course, some patients will continue to go there—from the jails and the general hospitals, and when we find they can't "use" our service!

Side III. So don't you worry about a thing. Our plans are set and we've covered all eventualities. It's all in our application. This is the greatest thing since penicillin, (or you can insert there one of the products of the sponsor of this series.) No problem between our out-patient clinic and the general hospital. The attending physicians and the hospital administrator understand

the center concept. Our clinic director knows all about its new role.

Well, enough of that stereotyping. I have, of course, overdrawn terribly, describing in lurid form the excuses and rationalizations that are often given as a way of resisting change or fully accepting it. Total resemblance to a hospital or center group, living or dead, would be appalling!

Can we not all agree that we are dissatisfied with our present system for delivery of mental health services? Can't we work at developing new systems built not on air but on the accomplishments and heritage from the best of our predecessors? Where we must tear down, can't we build handsomely with the old bricks which link us to those who were every bit as dedicated as we who consider ourselves the currently enlightened? Can we modernize and adapt where this is most appropriate and serves the best interests of our people? And can we be brave enough to step forward boldly where there is no heritage or where our old material cannot be usefully employed in our new edifice.

This is a task for those in hospitals like Broughton and Dix and Umstead and Cherry. You are not asked to apologize for 1967 or 57 or further back. To the extent that you have given of yourself unstintedly in behalf of patients, you have reason to be proud, and your solid accomplishments speak for themselves. Mix all this with a candid appraisal of the deficiencies we have all been aware of. You are not being asked to step aside now so that progress may move past you. You are called to be part of it, to contribute to it. Can you banish that "we and they" feeling. Is this concept of comprehensive community services eating at you and causing you to be defensive and status quo oriented? The worst sin would be to have a secret stake in its possible failure.

If there is a weakness in the new community programs I see, it is that state hospital people who have lived longest with the lacks and failures of communities, have failed to be in there pitching, shaping these new programs which may be long on enthusiasm and short on know-how.

If the day *should* come when we can all say Hospital X is not needed any longer and our patients are being better served elsewhere in the general hospital, in the day center, the out-patient clinic, in their home—well isn't that what we've all been working towards. The fact that this may be visionary does not relieve us of the responsibility to work for it. And if this possibility seri-

ously threatens any of us, then it is time to take a hard look at the hospital's and our own goals for patient citizens. No pun intended when I wrote this, but it occurs to me they have indeed been patient.

As an NIMH representative I am committed to the improvement of State Hospitals and their development to meet today's needs. As might be expected, I am also strongly committed to the growth of the Comprehensive Community Mental Health Center as an important core in the system of overall services. I am not by that fact committed to a "building" or an unchanging model or a nationwide network of identical programs which struggle to grow in the different soils of this vast and diverse country of ours.

Currently, a major motivating force for the development of comprehensive services is the Federally financed program which is linked to state and local efforts. It has its requirements and its rules and while they are not perfect, their insistence on at least five basic components does affect the ultimate shape of things, as the legislation was meant to do.

There are those who spend their time fighting these policies as restrictive, and who mutter darkly of Federal control and interference. As I work with these same policies here in your state, with your state agencies and local communities, and throughout Region III, I espouse these requirements and view them as a springboard to creative programming. I find them flexible enough to provide for the needs of Halifax and Fayetteville and Charlotte, and hopefully for Morganton and Asheville and other neighbors of yours. The fact that we differ at times and dicker at other times is important to the sound development of the local program as well as the developmental effect on national policy.

The guidelines are firm, for example, in their insistence that beds be available to patients near their home. But these same guidelines have been utilized sucessfully for the metropolitan areas and an Appalachian town in Eastern Kentucky. Centers already funded are serving dense populations of 200,000 and the sparsely settled areas of the Great West. There are bustling day care units of 30-40 patients in highly structured programs in cities. There are smaller, home styled but equally effective day care efforts involving 6-8 patients in church basements in rural small towns. There are highly organized emergency services and suicide prevention centers, and other smaller programs which insure that the occasional emergency in a rural area can be and has been provided for.

The firm thread that must run throughout is continuity of care and concern for all the people in the area the center has pledged itself to serve. It is this element that distinguishes our current effort whether we talk about a complex of services under one roof and management, or an effective joining of heretofore completely separate services to which new elements have been added.

To the consumer, a word I would rather not use, but it has worked its way in—to the citizen, the client, the patient, to the community at large, it must all feel and be like one system of care. If there are relationsfiips to be developed, strengthened, worked out, then that is our task, and shouldn't be added on to the difficulties of the person who seeks help for his own problem. It's an awesome responsibility on us as professionals to rise above selfishness and a false institutional pride.

I have spoken in other places about the fact that I thought the people generally are asking for all this. It is no longer what we in our wisdom feel they should have and deign to provide. They will understand our difficulty in delivery, will be sympathetic to our great manpower problem, and even to our lack of all knowledge. They will not understand our holding back from this idea, our unwillingness to work at it in relation to their needs.

I remind myself now that these are called Geigy lectures and I am afraid that's just what I've been doing. But some of you old friends of mine know that I always presume to say things here that I might offer more tentatively elsewhere.

You are fortunate in this state in that you have been up and doing in Mental Health these last few years or roughly since the day after Dr. Eugene Hargrove was appointed commissioner. There is a vision of comprehensive mental health services in North Carolina, which unlike most visions is based on sound planning. The "we and they'ness" I spoke of earlier is breaking down, the hospital and community separation chasm is filling in, and the state and local lions and lambs are sitting down together in an atmosphere devoid of either roaring or bleating. And lest anyone be confused by my last remark, let me say that I've met quite a few lions who weren't employees of the State Department of Mental Health.

One is supposed to close on an optimistic note, and I continually harp on the fact that they don't let any pessimists run loose out of Charlottesville. Enthusiasm we need, and it has to be fed daily for if this task of ours was easy we'd have done it yesterday and rested today. Its been my privilege tonight to speak to a very important audience, the people who are going to really do some-

thing about the "Relationship of In-patient Programs to Developing Mental Health Centers." At another meeting here in North Carolina some time ago, I expressed confidence in the ability of your hospitals and community programs to blend into a comprehensive system of services to and for all your people. Nothing since then has made me less certain. If you can keep Mr. Geigy interested and you reach number sixty-six in the series, I'll be delighted to come back and have you lecture to me. And I'll give you a title—"How the West Was Won—for Mental Health."

Mental Health and Mental Illness: Must They Be Dealt With Separately?

Brooke R. Johnson, Ph.D.[1]

Since 1756 with the establishment of the first public institution in the United States at Pennsylvania Hospital which accepted mentally ill patients, many problems and controversies have raged concerning the institutional care of the mentally ill. Without reviewing in detail the punishment, custodial care and treatment of mentally ill people in institutions, let us consider the "personality development" of the mental hospital. With the removal of mental hospitals from the community (if not physically, psychologically) one might consider the entire institution as an unwanted child who has been rejected by the family in numerous ways. One form of rejection is impersonal care and indifference; other expressions of rejection tend to be more active and to be reflected in hostility in the emotional atmosphere and in mishandling rather than simple ignorance of the child. It has been demonstrated that a deprivation in relationship is accompanied by a reduction in sensory stimulation, and the common result is intellectual retardation. Experimental studies with animals have demonstrated that when they are reared with restricted stimulation, they tend to be timid, dull, and stereotyped in their behavior. Occasionally, the result is apathy even to pain. Under conditions of inadequate sensory stimulation, the sense organs may even fail to develop.

If the above described "personality" of mental hospitals sounds familiar to some of us, we should now consider the setting in which this "personality" developed, the responsible factors for its development and corrective measures to modify its "personality." Considering the development of the state mental hospital and bearing in mind the current concept of community mental health centers, discrepancies in philosophies are apparent. Some of the reasons that mental health centers and state hospitals do not always work together are suggested in an article in the 1966 *Community Psychology* report of the Boston Conference on the Education of Psychologists for Community Mental Health. Some of the ideas touched upon by this article plus remarks of colleagues I have heard are: tradition of the state mental hospital as a custodial institution, geographic separation, lack of

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communication, staff brought up in custodial tradition, competition for state funds and personnel, common attitude that "anything is better than going to a state hospital" very strict admission procedures, inadequate staff and working conditions in state hospitals, poor therapy programs, attitudes which state hospitals have that consider others as trying to use them instead of cooperate with them and the fact that many mental health centers will not treat out-patients who have returned to the community from a state hospital.

In an article appearing in the fall, 1965, issue of the *Community Mental Health Journal* entitled "Professionals' Views on the Need for Psychiatric After-Care Services," thirty-four social workers and forty psychiatrists were interviewed concerning their views on the needs of recently released patients for after-care services. In this article, the social workers and psychiatrists in four Ohio state mental hospitals were interviewed concerning their views. These mental health professionals thought that ninety-five per cent of the released patients should be receiving more than two and one-half separate kinds of services, but that only seventy-seven per cent of the ex-patients were receiving as much as one service. Thus, in terms of the number of services, only one-third of the need is being met. Needed post-hospital services were indicated as follows: medication, supportive psychotherapy, casework services, nonresidential halfway centers, vocational services, residential halfway houses, intensive psychotherapy, day hospitals, night hospitals, and others. Obviously, if the institution's goal of returning patients to a useful, productive life in their communities is to be accomplished, these services must be available to the patient in his home community. If the patient is to be reassimilated into the community socially and vocationally, he simply cannot afford the time and expense of returning to distant hospitals for the after-care help he almost always needs in finding his place in the community again. The literature is in accord and support of the idea that the services of a community mental health center should be available to whoever needs them, regardless of whether those who come for help have been patients of state institutions before. In fact, the central concept of the Joint Commission on Mental Illness and Health is *comprehensive community care*. The Joint Commission's final report in 1961 grew out of a series of comprehensive studies begun in 1956 emphasizing the need for community participation in after-care and rehabilitation for the released patient.

These concepts in no way distract from the community mental health center's dedication to the prevention of mental disorder. Even if first priority is given to getting at the source of mental illness, the cooperation of the hospital and the local mental health center in the out-patient treatment of released patients can be accomplished without stifling the former endeavor, as explained in an article by Dr. Paul Boyles appearing in the October, 1967, Supplement of the *American Journal of Psychiatry*. In June of 1965, Broughton Hospital, a typical large, rural state hospital, was divided into four geographic units, one of which was Unit C, from which the reported study was drawn. In addition to the simple division, Unit C developed a new program that embodied the concept of adequate community after-care. Without significant increases in money or personnel, the Unit helped to develop three satellite aftercare clinics where continuity of care was maintained, partly through the innovation of traveling psychiatric teams that saw patients in the community clinics, made home visits when necessary, and cooperated with local agencies. Dr. Boyles felt that an active community program was essential for the proper functioning of the Unit. Only with community support could the long-term patient be returned to the community, the acute patients be treated and released quickly, and the return rate be substantially lowered. A statistical evaluation of the first twelve and one-half months of operation revealed a drop in patient population of forty-two per cent. Even though the statewide admission rate has climbed steadily, the admission rate to Unit C showed no change. Only 5.6 per cent of fifty-four first admission patients who were released in eight days or less required readmission. The readmission rate for all patients released during the year was 12.6 per cent (6.6 per cent for all first admission patients). Of all first admission male patients who held a job prior to hospitalization, ninety-two per cent went back to work shortly after leaving the hospital, with three per cent still involved in rehabilitiation. Thus, an evaluation of the first year of operation of Unit C reveals a good measure of success in reaching the goal of establishing a community-oriented type of intensive treatment.

With the initiative demonstrated by Dr. Boyles and his Unit C staff (which incidentally provided considerable psychiatric service to commuity patients who had never been in Broughton Hospital), a very active after-care program has become an integral part of the community mental health center's operation. Community involvement in the after-care program has included the

development of a drug program for medically indigent patients, vocational rehabilitation, psychotherapy, inter-agency consultation regarding patients, and any service available that has been offered to anyone else in the community.

Following up this initial stage of cooperative endeavor, future plans call for a sharing of eight staff members between the New River Mental Health Center and Unit C in Broughton Hospital. A psychiatrist and nurse will have their primary responsibility at Broughton Hospital, another nurse will have primary responsibility in the mental health center, two psychologists will have primary responsibility in the mental health center, a social worker will have primary responsibility in the mental health center, an alcoholism program coordinator will have primary responsibility in the mental health center and another psychiatrist will have primary responsibility in the mental health center but will be paid from Broughton Hospital funds. All eight of these personnel will be working in some way on a regular basis in connection with both the mental health center and Broughton Hospital. Although budgeting matters and administrative details will probably be complicated in the initial stage, it is felt that the long-range goals of better communication and cooperation and better care for the patient will be accomplished much more quickly by working together this way.

It is exciting to imagine all the possible things that could be accomplished by joint efforts. With the national trend of returning state hospital patients to their home communities, one might expect many problems and misunderstandings to come up unless there is an unusually strong joint effort on the part of the state hospital and the community mental health center. Even with the joint efforts of the above described program, there are occasionally patients who are returned to the community too early and patients admitted to the hospital who could have been treated in the local community. The answer to this problem is probably more refined techniques of evaluation before admission and before discharge but even then errors are likely to be made; and whenever this happens, it is much better to have good communication and understanding between the state hospital and mental health center.

The success of the above described cooperative venture may be attributed to Broughton Hospital and specifically Dr. Paul Boyles in Unit C who provided psychiatric service to a community mental health center which had no psychiatric service. In so doing he brought to fruitition the unusual concept of a state

mental hospital developing a broad based program involving community resources for continuing patient care. He has led the withdrawn child into a dynamic and meaningful relationship with the outside world.

Presented to the Worshop-Laboratory Training Program of the North Carolina Foundation for Mental Health Research, June 11, 1960, by Brooke R. Johnson, Ph. D., New River Mental Health Center, Boone, North Carolina.

Consultation as a Method of Providing Mental Health Services for School Personnel[1]

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It is generally agreed by mental health professionals that one of the best ways to reach the largest number of people at the earliest time in their lives is to apply mental health knowledge in the schools. I am going to suggest what we can do in the schools to provide mental health services and especially to prevent the development of emotional disorders and promote the development of psychological health. I am going to focus, but not exclusively, on what we do in the Halifax County Mental Health Program.

In most sections of the country where there is a shortage in mental health personnel, the best use which can be made of mental health professionals' time is to work with those people who are already coping with mental health problems as part of their routine responsibilities (Eisdorfer, Altrocchi, and Young, 1968). In the schools this means teachers, principals, guidance counselors, speech therapists, reading therapists, school nurses, and occasionally other school personnel such as a kitchen helper I once had to work with because she conspired with a child to hide the child from her teacher when the child escaped from class. The central feature of our program, therefore, is mental health consultation with these key care-giving people. Our goals are to prevent the development of emotional disorders and to provide a sort of psychological immunization by helping the school personnel to become more effective in their regular work by making them more sensitive to the needs of their students and more comfortable and adept in their relationships with them, all entirely within the context of their normal professional responsibilities and without any attempt to make them into junior psychiatrists or psychologists. The program has also been guided by the principle that it is better for the mental health professionals to come to the community than to have a patient or client or student travel to a major health center (Eisdorfer, *et. al.*, 1968). Thus, while we do provide limited mental health services for disturbed children in the Halifax County Health Department,

[1]Address presented at: The Mental Health Section of the annual meeting of the North Carolina Public Health Association, Winston-Salem, October, 1966.

most of our work connected with the schools is done in the schools themselves and sometimes in the homes of the children.

Another guiding principle in the development of our program—a principle which, incidently, is identical to a principle used in industrial consultation—was that we should start at the top. When Dr. Eisdorfer first began consulting in the county he met with all the school principals in group consultation sessions. These sessions were a necessary first step to orient the principals and allow them to become comfortable enough to invite the consultant into the schools. When we are invited into the schools, our aim is prevention and our prefered preventive technique is consultation with the school personnel. However, one must be willing to adapt oneself to a certain extent to the school's needs. Let me try to outline for you some of the things that we do in the schools, starting with those functions which are least preventive—that is, direct clinical services—and ending with attempts at primary prevention of emotional disorders.

Clinical services. Many schools, especially in rural or slum areas, have desperate needs to have the consultant help them with emergency clinical problems. Often we can be of considerable consultative help to the school in handling such problems, but sometimes there is no choice but to help the student or his family directly. Therefore, we are available for brief diagnostic or therapeutic interviews with students and their families. In our brief, direct work with individual students, we have often been able to be of considerable help, sometimes in less than an hour, to students who are distressed and want our help, but we are rarely able to be of much direct help to a student who is upsetting the school—by underachievement or rebellion, for instance. This is where consulting with the school personnel or working with the families is more effective. It seems to be an axiom of work in schools that the children who are behavior problems usually come from families with problems. We have often been successful in inviting some or all of the student's family in to meet with us and, needless to say, we have had to deal with every problem imaginable, including open warfare in a family. I'm sure that we have had very little impact on some of these families but, in a remarkable percentage of cases, a relatively brief meeting with the student and his family has resulted in a change in school adjustment or general adjustment for the child that has, according to our best observational criteria, been permanent.

Tertiary prevention. Sometimes in the schools we are attempting to limit the disability or impairment that results from

a psychological disorder. For instance, we can often help the school understand and tolerate a student who is under stress, or in psychotherapy, or has returned from a state hospital or from a training school. In such situations consultation can sometimes be of maximum benefit. For instance, recently I talked at some length with the third grade teacher of a boy who had been a serious behavior problem the spring before after having been serverely beaten by his father. When I inquired about whether that spring's consultation had been useful, the guidance counselor and the teacher told me that the consultation had been very useful and the boy was no problem at all. As we talked further, however, it turned out that, while the consultation had indeed evidently been rather successful, one reason that the boy was no behavior problem now was that he was sleeping in class! I then needed to explore with the teacher rather gently why she let him sleep. It turned out that she was simply afraid that if she woke him up he would become the behavior problem that he was last spring. With some encouragement and understanding she was able to see that this wasn't necessary and that she probably could afford to wake him up. I think you can also see that perhaps some secondary and primary prevention was involved here in that if the boy were allowed to sleep through most of the third grade, his school progress and thus perhaps his vocational and personal adjustment might be seriously handicapped.

Secondary prevention. Often we are involved in attempts to help the schools limit the duration of disorders, limit sequelae, and reduce the possibility of contagion. There is no question in our minds that the vast majority of the time children are referred to us for consultation at a much earlier stage in their troubles than would be the case if we were not going into the schools. There are many examples, but perhaps one of the more dramatic ones is school phobia. If there are mental health resources in a community, a progressive school system will eventually refer the child to a clinic, but by the time the referral is made and the child is seen the school phobia may be well entrenched. Following the work of Wallace Kennedy (1965) at Florida State University, we have urged the schools to handle school phobias immediately and directly in the following manner. If the school phobia is not a symptom of a very severe personal or family problem (in which case clinical referral would be necessary), the school personnel should involve both the mother and the father immediately and convince them to be allies in the plan to get the child firmly back to school as quickly as possible. They are instructed to reward

the child for coming to school. The mother's fears of separation are handled indirectly and the part of the mother who wants healthy independence for her child is supported directly, as well as indirectly through the father. The school and the family are told what to expect—symptoms for the first day or two but quick reduction of symptoms if they remain firm. This system works the vast majority of the time. School phobia seems to be an especially important area around which we can work with school personnel because, with increasing educational pressures, it can be anticipated that we will have a great deal of school phobia and because a school properly oriented and backed by mental health consultation can handle school phobia effectively and quickly in the vast majority of the cases, whereas ineffectual handling can lead to an entrenched school phobia which is very difficult to resolve.

An example of an attempt to shorten the duration of a disorder as well as limit the sequelae happened recently in a rural school. The school consulted me about how they might deal with the limited academic motivation of some of the children in the special education class. I pointed out, and as they already suspected, that such motivation usually comes from the family. Out of this discussion grew a plan to meet with all the parents of the children in this class so as to help them understand what the class was about and what the children's problems were, to help them refrain from simple things like calling the children dumb, and to provide some means of building self-esteem in the children. It is encouraging to note that the teacher reported one month later that there had been a dramatic increase in academic motivation in the class since that meeting with the parents.

An example of that aspect of secondary prevention which deals with reducing the possibility of contagion comes from the example I used above in another context—the boy who was severely beaten by his father. The school nurse and the school personnel equivocated long enough about turning the father over to the authorities last Spring so that the bruises and scars disappeared. By that time the major school problem with the boy was that he was acting up a great deal in class and was in the process of bringing most of the class along with him in open rebellion against the teacher. She had just about lost control of the class and claimed that she was about to lose her mind. We developed a plan whereby she could gain the rest of the class as allies in working with this troublesome boy rather than their being allied with him against her. She wasn't sure she could carry this out by herself,

so I met with the class and engaged them in a discussion about their problem with the boy. I purposely picked behaviors of his which must have been distressing to them, such as putting tacks on their seats, and asked them if they liked these behaviors. Of course they answered with a resounding "No." Thus you can see that it was eventually possible for me to get them on the teacher's side in persuading the boy not to engage in such behaviors. The students themselves decided that they should tell him that they didn't like these behaviors, but at the same time they should give him attention and friendship when he showed more positive behaviors. Not only was this intervention helpful to the boy but it may have helped to prevent contagious development of behavior disorders in the other children.

Now what about *primary prevention*? It is probably correct to say that much of our or anybody else's work in the schools is not primary prevention because most psychological disorders do not begin or owe their primary etiology to school factors, but there are things that we and others do in the schools that are meant to have some impact on primary prevention. Irving Alexander and the school superintendent of Roanoke Rapids started a testing program involving all entering first graders with a view toward preventing the development of learning difficulties. Another plan with potential for primary prevention was suggested by a guidance counselor who said that he wished we could do something to help the young teenagers in their school who had severe family problems, such as alcoholism in one or both parents, about which they (the students) could do nothing. I think that this guidance counselor has picked out a high risk group and we are going to try to help these students with their family problems. We have no right, of course, to ask the parents to come in for family counseling and we might not get very far if we did so. What we are contemplating doing is having bi-weekly meetings with eighth and ninth graders who decide that they have family problems of this kind, with the hope of helping them to adapt to the problems and not give in to them, and to work out successful coping mechanisms without embarking on impulsive or self-defeating behavior such as early marriage in order to get out of the home. Perhaps you would be willing to call this psychological immunization.

Another idea about primary prevention arose out of a series of requests from high schools and junior high schools in Halifax County that we talk with groups of students. These requests came from solicitous and interested teachers who knew that the

kids had lots of problems that they wanted to talk about and were not free to talk to the teachers about. We have routinely fulfilled these requests. The discussions have often involved sex, boy-girl relationships, and marriage. We have begun to realize that, with these high school students, we may be able to have a real primary prevention impact by going much farther back in the life cycle than we had anticipated that we could. We have thought that the first time we have large numbers of people together is when they gatehr in the first grade or, in other states which are a little more progressive educationally, in kindergarten. People have, of course, thought of dealing with nursery school children or with newborn babies or with mothers pregnant for the first time, but here we have a chance to work with kids who not only are not already pregnant (most of them anyway) but have not yet even selected a mate for life. We are developing the idea that there is a simply desparate need in our high schools and junior high schools for sober, serious, frank course work and discussion of family, sex, and marriage problems. I have no doubt that all of you understand immediately how tense would be the reaction from many sources to such a proposal and how careful the planning would have to be. But let me give you one simple and dramatic example of the need. We estimate that about 25% of the students in one-particular high school believe honestly and sincerely that if a girl has not had sexual relations by the time she is 18 she will go insane! I think you can guess which sex initiated that myth and I think you can also see how the undermining of that myth might have numerous beneficial effects, including mental health effects.

There are many other ways we can attempt primary prevention. Let me mention a few. (1) Many consultants are using Gerald Caplan's (1964) crisis theory in their consultation. The idea here is that when a person is in crisis he can move in either healthy or unhealthy directions because the equilibrium is disturbed and if the consultant can work with the key care taking person at a time of crisis, the development of the disorder may be prevented. (2) Cowen and Zax (Cowen, Zax, Izzo, and Trost, 1966) at the University of Rochester have been involved in an elementary school consultation program and have been doing what many other people should do—evaluating the results of such a program. So far the results are very encouraging. (3) Sheldon Roen at the South Shore Mental Health Center in Quincy, Massachusetts has embarked on a program in which he teaches behavioral science to fourth graders with the aim of primary prevention. (4) Other

investigators like Nevitt Sanford at Stanford and Michael Wallach at Duke are proposing that the schools have a major role to play in the development of creativity in children and the development of the ability to use one's imagination. They claim, and I think most of us would agree, that the development of such qualities in children—which are usually ignored in our schools—should result in strengthening of the personality and broadening of the resources and flexibility of the person and that such strengthening should result in lessened susceptibility to psychological disorder. This is a massive and challenging goal.

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Attitude Therapy: A Workable Approach in Treating the Lower Socio-Economic Patient

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A number of vexing problems have become evident through the increased demand for psychiatric treatment stimulated by the recent federal mental health acts. An impressive body of literature now points out gross inadequacies in our method of evaluating and treating the large number of patients seeking help. To a great extent the increased patient load is made up of lower socio-economic patients. This paper is addressed to the problem of finding more effective ways to treat such patients.

Psychological and sociological descriptions of lower socio-economic patients seem to force one to take the position that these patients are either untreatable or that new methods must be employed. They are said to have low I.Q.'s and education as well as the associated triad of non-psychological mindedness, desire for physical symptomatic relief and an inability to "cooperate in psychotherapy" (1).

Bernstein (2) notes that such psychotherapeutic standbys as elaboration of meaning, feelings, motivations, and purposes are usually not part of such patients' "linguistic code". Hoggstrom (3) cites the inability of such patients to delay gratification for the sake of future gain and the feeling of being impotent to change their living circumstances as posing further difficulties in the use of traditional psychotherapy.

Lower socio-economic patient expectations regarding therapy are often in conflict with the therapist's viewpoint. The patient expects a medical-psychiatric interview from an active but friendly and permissive person (4). He expects quick symptomatic relief via the therapist doing something to him or for him (5, 6).

Mayfield and Fowler's investigation (6) describe this group as tending to deny feelings, to somatize, and to see the basis of their problems as outside themselves. Their maladaptive interpersonal maneuvers, while anxiety laden, are none-the-less ego-syntonic.

All the qualities listed above are generally believed to predict poor psychotherapeutic response. Since these qualities exist and

are not going to go away, some authorities advocate modifying traditional treatment approaches as the only rational solution. Given the magnitude of psychiatric problems in our poorer population, we can no longer dismiss them as "poor therapy candidates." Evidence exists that depth oriented approaches are contraindicated since they are more likely to drive lower socio-economic patients out of therapy rather than help them. This point is well made by Reusch (7), Brill & Storrow (1) and Aronson (4). Nevertheless, the myth exists that "depth psychology" is somehow better treatment (8).

Given these patient characteristics a more workable approach is obviously needed. Based on the above description of the lower socio-economic patient, the new approach should accept the patient as he is and make an initial therapeutic contract on his terms, concentrating on symptom relief. An overall program should be developed that affords the patient a corrective learning experience so that he is explicitly and repeatedly taught via day to day examples precisely the manner in which feelings, interpersonal interchanges, and environmental situations are related to his well being. He must also learn that he has some influence and control over tham. All levels of staff must prepare to interact along these lines.

Jones (9) asserts that these types of daily learning experiences can help a patient understand at least some of the motivations underlying his actions as well as the reciprocal impact which others have on him and he, in turn, on them. Kroft (9) describes the therapeutic community as one in which "no elements are set outside the treatment and all transactions are important as potentially therapeutic." His stated goals of treatment are:

1) helping to give the patient awareness of fellings and behavior,
2) having the opportunity to try new skills in a safe environment,
3) learning to become aware of one's impact on others,
4) developing an increase in self-esteem.

Patient variables as well as treatment facility and staff characteristics can militate against the realization of the ideal goals just described. For example, a hospital staff whose approach to patients is not consistent across all staff levels will not provide the precise, explicit, and repetitive learning experience required. Lack of consistency in turn implies poor intrastaff communications, vague treatment goals, or insufficient skill in carrying out treatment plans.

To summarize, the ideal treatment facility should offer the patient a corrective learning experience so that maladaptive methods of dealing with feelings, situations, or people are pointed out to the patient and discouraged in terms of, "it doesn't work" rather than "you are bad." More rewarding or adaptive methods are encouraged and reinforced. This experience is more likely to occur if the patient's interactions with the staff are consistent and if there is a coordinated, goal-directed program so that the patient knows what he is trying to accomplish and why. Attitude therapy with its inherent team approach seems to be an excellent vehicle to accomplish these goals.

The most extensive attitude therapy program is at the Veterans Administration Hospital in Tuscaloosa, Alabama. This program has been developed and well described by Folsom (10,11). Its use and development have primarily been in larger, neuropsychiatric type hospitals. The use of this approach in a general medical and surgical hospital which is also connected with a medical school presents some special problems. This has stimulated some special modifications and innovations at Durham.

The great value of an attitude therapy program is that it brings together very important principles of human interactions in a very concrete, easily teachable way. This has resulted in stimulating personnel from all levels to have a keen sense of playing a significant role in helping the patient to get well, coupled with confidence that they know what they are about.

The Durham V. A. Hospital treatment team is composed of a social worker, psychiatrist, psychologist, occupational therapist, physical therapist, rehabilitation therapist (sports, physical therapy, work placement), the resident and medical student of the patient being presented and at least one nurse and nursing assistant from the patient's ward. Within one to three days after a patient is admitted, data concerning him is presented to the team. He will have already taken a self-administered psychological battery which especially evaluates characteristic maladaptive ways of trying to get his interpersonal needs met and what he is seeking from the hospital. The major focus of the reports given by the social worker, ward physician, nurse and nursing assistant is also on the patient's habitual patterns of behavior that seem to be self-defeating. His assets and workable motivation for help are also assessed. The patient is then brought before the team and interviewed. Emphasis is placed on why he is here now and on what he hopes to gain from hospitalization. We listen very carefully in an attempt to make a "therapeutic

contract" with the patient. We are especially sensitive to any complaints of an interpersonal nature so that part of our therapeutic contract will be to help the patient learn how he might be evoking and how he might learn to prevent the very reactions which make him unhappy. For example, if a psychotic patient complains of losing jobs and of excessive control by the family, our contract may simply be to help him react differently to his hallucinations so that he will quit talking about them since this seems to result in the boss firing him or the family over-protecting him. We have used the establishment of a therapeutic contract on the patient's terms as the beginning step to engage the patient in an active effort to break out of the "pawn-in-the-hands-of-fate" position.

Next a decision is made as to in what programs the patient should be involved, such as occupational therapy, recreational sports, physical therapy, work (on the ward, in the hospital, or out of the hospital), and group therapy. One of five basic attitudes or a combination of the attitudes is then prescribed. Since all personnel who will have contact with the patient are part of the team, they are aware from the beginning what they are to look for in their relationships with the patient, what he needs to learn, and what basic attitude all can most effectively use with him.

The patient is then told in straightforward language what programs he will be in and what our goals are. Predictions are often made to the patient as to what some of his reactions will likely be. He is thus alerted to be more aware of his feelings and behavior. An attempt is made to engage him as a very active participant in the team and in his treatment. Because we have more personnel and more time per patient than is had in the Tuscaloosa program, we make more use of the team in terms of preparing the patient for his program. We especially prepare the patient for group therapy in which over half of our patients are engaged. Most of the preparation is couched in terms of his program being designed to interrupt a vicious cycle in which he seems cought. Strong attempts are made to interest the patient in looking more closely at what he is feeling and doing and at how he is influencing others.

The team has four such meetings each week. Followup meetings are held twice each week. At these latter meetings decisions concerning changes in the program, visits home, moving to a ward which is less restrictive, etc. are made. There is always

emphasis on responsible behavior in his earning increased privileges.

While the patient is in the hospital, the social worker and ward physician attempt to help the family understand what attitude therapy is about, in what specific programs the patient is engaged, and how some principles we are applying might be carried out at home. In several cases where the wife's cooperation was in doubt, she was brought before the team as a *team member*. The effect was to help her understand what we were doing and why, and how her interaction with the patient could enhance and maintain his improvement rather than reinstitute the old maladaptive relationship.

We will now describe our use of the basic attitudes.

Matter-of-Fact is the attitude most frequently prescribed. This approach is best described as honest, open, direct, and *non-hostile*. This attitude is most often prescribed for patients with various personality disorders, neuroses, psychosomatic problems, and some schizophrenic processes. Behavioral interpretations are made to the patient in terms of what he is doing and saying, whether it works and gets his needs met. This approach will most likely cause learning to take place if the patient does not feel attacked. Therefore, this attitude must be cast in a setting of friendliness and understanding even though firmness and confrontation are often a part of it.

The attitude of Passive-Friendliness is one in which the staff does not initiate friendly or authoritative interactions. If the patient approaches the staff, they react in a straight-forward, courteous, but not intrusive fashion. This attitude is used in patients who have various paranoid reactions or who in conflict-adaptational terms have a trust-fear or submission-fear conflict (12). The patient is told initially that we are aware he is angry or uncomfortable when people become friendly or close, or when they seem to be telling him what to do. Therefore, we tell him we will not force ourselves or a program on him. He is further informed that if he has any reasonable requests they will be carried out otherwise he will not be bothered. The usual expenience is that in 1-2 weeks the patient feels more comfortable, begins to trust the staff who have interacted as predicted, and he begins to approach them without so much suspicion. Usually a gradual shift to a matter-of-fact attitude is then made. The staff must be prepared to shift the two attitudes back and forth depending upon the patient's reactions.

Active-Friendliness is the attitude prescribed for the withdrawn, apathetic, and most often chronic schizophrenic patient. He must not be paranoid or depressed otherwise the attitude will be antitherapeutic. We tell the patient he seems to feel a failure at everything so that he has about given up. We assure him we are glad he is here and want to help him. He is told we will help him not to fail at anything. In all of his contacts he is approached in a very friendly, helpful manner. Anything he does that demonstrates the slightest initiative is praised. All activities of daily living and program activities are entered into by the patient and the ward personnel so that he has no failure. As he becomes more out-going or assumes more responsibility, we gradually shift to a matter-of-fact attitude.

No-Demand is the attitude used for the patient who is violent, in a panic, out of control. He is told he is angry or frightened, that everything seems to have gone wrong for him. He is then informed he will not be harmed in any way, and that we have only four requests: 1) he must not harm himself, 2) he must not harm anyone else, 3) he must stay on the ward, 4) he must take his medicine. Otherwise, he is told he will not be bothered. In some cases this does have a calming, reassuring effect. However, unlike the Tuscaloosa group, we do not maintain this attitude for an extended preiod of time. We feel many grossly agitated, disturbed patients should be given E.S.T. and restored to behavior that gives some dignity and makes possible more meaningful personal contacts.

The final attitude is called Kind-Firmness which is somewhat of a misnomer. Firm control is the attitude that is in fact carried out. This attitude is used specifically for patients who are depressed. The theory underlying this attitude is that people get depressed who have been unable to deal with anger openly and who have repressed or "internalized" it. Whether this is a universal dynamic or not is quite doubtful, but we have observed that the majority of our depressed patients are unable to deal with unpleasant situations or feelings directly. Depression, in part, also seems to be a maladaptive way to evoke nurturant responses from the environment. We do look for historical evidence that the patient is unable to be appropriately assertive.

The patient is told he is depressed and that the treatment is work. He is then taken to a room where he stacks popsicle sticks, sorts beads, sands blocks of wood, or bounces a ball. The therapist, most often a nursing assistant, is in complete control of the patient's every move. The patient is never allowed

to complete any task and is continuously criticized or corrected for his inadequate work. Except for several irregular breaks and meals, he is in the workroom all his waking hours. In fact, if he is unable to sleep he goes back into the room. The patient gradually becomes more and more frustrated and angry. It is very interesting that a patient often goes through the same various defensive maneuvers in attempting to deal with the unpleasant situations that are a part of his maladaptive life style. At first he may be very compliant as if he might do the work perfectly and then be rewarded. Next, he may make various physical complaints; however, he is told, "you are here to work and not to talk." He may try to make the therapist feel guilty or engage in various passive-aggressive maneuvers, but the therapist remains in complete control and the patient is faced with an apparently endless, fruitless task. Finally, he takes personal, direct responsibility for refusing to work. Instead of, "I can't," it is, "I won't." This reaction occurs with varying degrees of expression of anger. He is then taken out of the room and given tasks in which he can accomplish something. The angrier he is, the more the task will be geared to let him blow off steam. As he settles down he is highly praised for his stand. He is told his inability to be honest, open, direct with feelings is a major reason he has been depressed. We suggest he can now be more aware of feelings and situations and deal with them in a more appropriate way. One patient is in the midst of an angry tirade after having come out of the workroom stopped himself in the middle of a sentence as if surprised and said, "You can't feel depressed when you are angry." The patient is often programmed for group therapy where the recognition and appropriate expression of feelings is rewarded and generalized to other interpersonal encounters. All the people working with him are quick to reinforce the stand he took in the workroom and are sensitive in helping him recognize feelings and to deal with them appropriately. We do not believe the expression of anger has some sort of magical effect but rather that the patient has been helped to face an unpleasant situation in a direct way rather than develop symptoms. Apart from lifting of the depression, these patients invariably have greatly increased self-esteem. They usually make very good group therapy patients because they have had a dramatic learning experience concerning the need to be more aware of feelings and to deal with them in a more appropriate way. Symptomatic relief associated with this

more open approach on the patient's part is a powerful reinforcing influence.

Since we have teaching responsibilities to medical students and residents, some modifications and innovations have been made in our program. There is a tendency for the ward physician to feel somewhat threatened by the team approach. His model of the one-to-one relationship and the idea of the doctor being in rather complete control is shaken. There is sometimes some resentment over "non-medical" personnel sharing in decisions concerning patients. We have dealt with this by: 1) having a psychiatrist as the team director or consultant rather than a person from another discipline, 2) letting the ward physician direct the team when his patient is being presented, 3) leaving all medical treatment (E.S.T. or drugs vs Kind-Firmness) in the hands of the ward physician, 4) letting the physician make decisions over discharge of the patient. The resident physician is introduced into the program by pointing out that it will be an opportunity for him to learn how to direct and utilize a team. The basic function of the team is presented as an aid to the physician to help him better utilize the entire hospital to afford a corrective therapeutic experience.

In the team; we emphasize the therapeutic contract, explicitly define our goals, and present treatment to the patient in terms of interrupting self-defeating cycles. This all places great responsibility on the patient for his treatment and helps relieve the frustrating burden often placed on the ward physician by a patient who feels he is a "pawn-in-the-hands-of-fate" and who essentially tells the doctor, "I'm your problem—you do something to make me feel better."

Our use of attitude therapy and the team has afforded us an excellent opportunity to teach and emphasize some important facets of psychiatric treatment. Since we focus on the patient's patterns in relating to his family and community, students are helped to appreciate the important influence of the latter. There has been an increase in work with families and involvement with community resources since we began the program. Utilization of the Employment Security Commission has been helpful here. There have been fewer direct discharges from the hospital and more concrete planning for reintegration into the community and the family.

We also find this approach helpful in breaking down the dynamic vs organic dichotomy that students tend to see as an either-or proposition. Our approach is, that regardless of the

diagnosis, the presence of brain damage, or the presence of a severe schizophrenic process, the patient can learn better ways to deal with feelings and situations so as to; get more of his needs met, have a heightened sense of self-esteem, and feeling of control over himself and his environment.

One final note of the value of this program is its appeal to personnel throughout the hospital and to the public in general. The lack of jargon, the common sense approach, the clear action implications greatly enhance its acceptance.

Summary:

There are many difficulties in carrying out an effective psychiatric therapeutic program for lower socio-economic patients. These problems are discussed from various theoretical and practical points of view. Attitude therapy with its inherent team approach seems to be an excellent vehicle in helping to develop a true therapeutic community for these type patients. The Durham Veterans Administration facility is a general medical and surgical hospital affiliated with the Duke University Medical Center. This has stimulated various modifications and innovations of Folsom's (10) attitude therapy program and these are discussed. Some of the special problems as well as teaching opportunities resulting from the rotation of residents and medical students through our Service are elaborated.

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BOOK REVIEWS

How to Live With an Alcoholic

$1.00, 1967, by JORGE VALLES, M.D.
Essandess Special Editions
A Division of Simon and Schuster, Inc.
630 Fifth Avenue, New York, New York 10020

Dr. Valles is Chief of the Alcoholism Unit, Treatment and Research, Veterans Administration Hospital, Houston, Texas. He is a member of the American Medical Association, American Psychiatric Association, World Center of Psychodrama and Group Therapy, and the Houston Council on Alcoholism. As the publisher states in a letter accompaning the book, "*How To Live With An Alcoholic* is a warm, human book written with perception and sympathy gained through long involvement with alcoholic patients and extensive use of therapy, counseling, and psychodrama."

In reading this book, one should keep in mind the fact that Dr. Valle's was writing for the wives of alcoholics primarily. It grew out of his experience in delivering "occasional lectures to various groups of Al-Anon" on the invitation of the Houston Council on Alcoholism. He states that he had some doubts about his lectures until in a chance encounter with a woman, who had heard most of them told him how much his lectures had helped her. Dr. Valles says in the Introduction, that he had intended for some-

time to write on alcohol addiction for the medical profession, but after this experience he decided that the doctors could wait and "that my first words should be directed toward these women who day after day have to live some sort of life with an alcoholic."

However, as he says, "the book may well be of interest not only for the troubled families and friends of the alcoholic, but for any person, layman or professional, with an interest in this intricate problem of alcohol addiction."

If one studies the book chapter by chapter, or perhaps lecture by lecture, none of which cover more than five or six pages, one is greatly impressed by the author's logical presentation of his concepts, his insight, the simple and direct methods of emphasizing the significant aspects of the alcoholic's struggles with himself.

The great question: "Doctor, what can I do to help my husband?" One begins to see that the answers are not simple or "something that lends itself to a quick, precise description and definition" because "the question involves a human being, and this in itself is a complicated phenomenon. An alcoholic human being is even more complicated, for he is one who changes constantly, one who demands to be treated carefully and, above all, respectfully." The doctor asks the reader "to be patient and give us time to explore the question so that I can really say what I think when I hear the plea, "*Doctor, what can I do to help my husband*?"

Alcoholics are human beings: "You may well say on reading this title that this is a pretty obvious statement. Actually it is. But it needs to be said, and often, because like many other obvious concepts this one is frequently overlooked or forgotten." "What I mean to say is that the human being is in a constant state of change. He is not a static element, fixed and immutable, as is an object. To speak of something that is forever becoming somewhat different is not an easy matter, for it exposes us to contradictions within our own ideas and within our expression of those ideas. It is indeed risky to make statements concerning human beings, for we must always be ready to clarify them and to concede that we may be wrong or mistaken in a particular instance."

The author moves on to say "our own concerns and worries will influence our concepts. Our point of view is always dependent in great part on our own attitudes toward ourselves and toward others."

"At this moment, having mentioned the word "attitude", we shall have to pause and explain what we mean." To the dictionary definition he adds, "an attitude presupposes a prejudice or a conglomerate of prejudices. For example, when we say that someone has an attitude of intolerance, it means that he is a person who has preformed ideas that are unshakable. He accepts no ideas that are different from his own, nor does he approve of people who have such ideas."

"In opposition to this is the tolerant attitude of the person who is invariably disposed to listen and to weigh the points of view of others. He can examine fresh concepts, and he can recognize the validity in new ideas even when these are in contradiction to his own way of thinking or doing. He has an open mind and an open spirit, and will enter a discussion ready to listen, disposed to reason, and willing to accept a difference in viewpoint regarding things and people."

These different attitudes are illustrated by a brief case history of John, a 40 year old man, an alcoholic, who is married and has two children. "The well-meaning neighbor says, *John is a lazy bum.* The store manager where John used to work says, *John is a good samesman, but . . .* His father-in-law says, *John is irresponsible and will end by killing by daughter.* The religious zealot of the family says, *John is an incorrigible sinner.* John's pal of the barroom brawls says, *John is a good friend, always ready to help anyone.* The policeman says, *John is a hopeless drunk.* The family doctor says, *John is a sick man.* The wife says, *John is a good husband, a good father, but . . . .*"

"When someone, and most particularly you, his wife, tries to understand the alcoholic and tries to see him as the human being he is, then the first step, has been taken toward arriving at an answer to the question: What can I do to help my husband?"

In his discussion "Lets talk about alcohol" he is not concerned about its chemical composition. His concern is physical illness resulting from alcohol and the psychological effects which it produces. What concerns the alcoholic "is one simple characteristic of alcohol: It gives him that which he asks of it." "Emotionally the alcoholic finds in alcohol the solution to all his problems, to all his aches, to all his suffering." "The chemist is not the least interested in whether or not alcohol provides courage. In the chemical formulas there is no mention of this ingredient, nor is mention made of the euphoria the alcohol provides."

"But the young man who is beginning to take his first drinks and down his first cans of beer can tell you about this. One or

two quick ones, and he feels gay, talkative, sociable and thoroughly alive. This initial sense of joyous self-confidence is of great importance, for it is actually the bait that hooks him to alcohol."

"Throughout the history of man, alcoholic beverages have been associated with the gay, the colorful, the dashing, the embellished world that attracts all of us. Very few people know, nor can they perceive, that alcohol is a vicious and dangerous drug."

It "is the fountain of untold sorrow and wretchedness" and "can very well be a drug as dangerous as morphine or opium or heroin."

"It is widely believed that alcohol is a stimulant. The effects we see produced in a person who is even slightly inebriated would lead one to think so. However, the fact is that alcohol acts as a depressant on that part of the brain that controls our behavior."

A few comments about the meaning of certain words for the alcoholic need to be made. The words, loneliness, bored, blue, depressed, remorse, fear, anziety, anquish, and agony are unpleasant for all of us, but for the alcoholic they connote terrifying experiences. For example, "a consequence of the inability to communicate with others is an emotional state that we shall call loneliness." Loneliness and the state of loneliness "express two vastly different emotional experiences."

"If one wishes, he can be alone at almost any given moment." The state of "loneliness cannot be arranged. It is a condition that comes uninvited, unwelcome. We cannot will the state of loneliness, nor can we easily escape from it. Loneliness is characterized by one special evil: It reduces our world to insignificance. The lonely man is deaf to every melody, blind to every beauty. His faculties are muted, his self is buried. He is unable to think, unable to free himself, It is as if he were paralyzed."

"Loneliness is a destructive force. It is a desert composed of melancholy, despair, emptiness, anxiety, and agony. It is the gate to suicide. Loneliness is a tragedy that enshrouds the alcoholic. It destroys him little by little, for it drives him to drink more and more."

Those who are familiar with various books on alcoholism say that this is the first book that contains a discussion of the phase known as *building up to drink* or *BUD*, a crucial condition which Dr. Valles believes must be understood by both the alcoholic and his wife or other relatives if sobriety is to be achieved and maintained.

"Upon mention of the word alcoholic we should immediately form a mental picture of a human being in whom everything is at

an emotional boiling point, in whom every reaction is part of a continuous confusion, and in whom one simmering emotion is superimposed upon another. We must see him as an individual who is constantly on guard against an attack of anxiety. We must consider that this state of alert in which he lives is in itself the initiating element of his anxiety; thus, every difficulty that arises, no matter how insignificant, is a motive for an emotional reaction on a highly magnified level. We must bear in mind all that we have said concerning the alcoholic and his emotions if we wish to understand this very important concept of BUD."

"Close observation will reveal that even before he has had his first drink, he is already in a condition of emotional confusion. Actually, it is emotional inebriation. That is to say that the alcoholic is already drunk before the ingestion of alcohol. My experience with many hundreds of alcoholics has convinced me that the alcoholic loses his control and power of volition not when he has had his first drink but before taking it."

Doctor Valles describes the cycle which he calls "BUD, or Building Up to Drink" by means of a chart on which six zones are indicated, the one on the left being the "starting point", the next the "initial zone", third the "up zone", fourth the "danger zone", then the "down zone" and last on the bottom right "relaxation."

At the starting point, "the alcoholic feels somewhat moody, a little bored, and rather restless. This condition progresses steadily, gaining momentom as it expands. Now the alcoholic is in what we may call the initial zone. Here his irritability is reaching a high pitch and his emotional content is rising. From here he enters the up zone."

"Soon symptoms of a physical nature make their appearance; his hands begin to tremble, beads of perspiration accumulate on his forehead and in his hands. He is now approaching a plateau, the danger zone. Here all symptoms, emotional and physical, are highly intensified. He is uncomfortable, uphappy, ebbing in every area. The duration of the danger zone varies according to the alcoholic and depends on the circumstances in which the BUD occurs. It is usually resolved by crisis, that is, by rapid alcoholic inebriation. However, the abatement of this intense stage is possible, if the alcoholic can be helped through his anxiety and made more comfortable."

"After the danger zone he enters what we call the down zone. Here the symptoms begin to diminish. After this he passes to the zone of relaxation."

"The importance of BUD cannot be overemphasized. The alcoholic who is trying to maintain his sobriety must be made aware of the manifestations of BUD in all its details. Principally he must learn to recognize the onset of this condition. It is equally important that those who live with him learn to recognize and appreciate all the symptoms of BUD and its gradations."

"The sooner we recognize that he is entering a BUD, the easier it will be to control the progress of the up zone. Thus we can delay and perhaps prevent its advance into the danger zone. Every effort should be bent toward that end."

For once he enters the danger zone, a state of acute anxiety sets in. It is urgent that this be alleviated as soon as possible, for if it is not, he will almost inevitably return to drinking."

"The danger of the BUD is greatly diminished if the alcoholic can be taught to recognize its onset. If he can learn to be aware of its starting point, he will understand the significance of the changes occurring within himself, and this in turn will reduce his anxiety or at least prevent it from rising to perilous levels."

The suggestions, or sometimes it seems the musts, may appear to be more responsibility than the wife of an alcoholic can carry. The author points out some of the resources available to help her, for example, Al-Anon. Al-Anon is not to be confused with Alcoholics Anonymous, a well known organization for alcoholics whose members are making an effort to achieve and maintain sobriety. "Al-Anon is no longer an experiment. It is an active growing force that is constantly giving hope and purpose to the daily lives of thousands of relatives and friends of alcoholics."

"Many who are now members of family groups have already seen their loved ones achieve sobriety, but they have found that life with a sober alcoholic can present special problems of adjustment. Others still have active problem drinkers in their homes. All of them need the fellowship which Al-Anon affords. All of them find strength and comfort in one of Al-Anon's tenets, the Serenity Prayer:

> "God grant me the serenity to accept the things I cannot change, the courage to change those things I can, and the wisdom to know the difference."

Dr. Valles makes it quite clear that the alcoholic and those with whom he lives must seek professional help. He also points out the disappointments which the alcoholic and his family may experience because of the false hopes that commitment arouses. "If the alcoholic is not ready to work toward obtaining his per-

manent sobriety, these periods of enforced hospitalization are completely worthless. Furthermore, such periods of hospitalization often make it more difficult to accept hospitalization in those institutions where adequate programs for treatment of alcoholism have been established."

In addition to giving help to the wives of alcoholics, it is apparent that it is the author's purpose to clarify misconceptions and confusion regarding alcoholism and to help break down prejudice directed against the alcoholic. On the while the purposes of the book are carried out effectively. It is recommended reading for everyone who can read and understand.

R. Eugene Brown
Consultant on Social Work Programs
N. C. Department of Mental Health

NEWS BRIEFS

NORTH CAROLINA NEUROPSYCHIATRIC ASSOCIATION AND DISTRICT BRANCH OF THE AMERICAN PSYCHIATRIC ASSOCIATION

Resolution on the Importance of Sustained or Increased Support of Mental Health Programs

Passed by the Council of the American Psychiatric Association, May 1967

In the face of a constantly growing population, the fifty states have accomplished a steady and substantial reduction in the numbers of persons in their mental hospitals. This decline, which began in 1954 and has continued in each succeeding year, has been accomplished both by increased expenditures by state governments and by new methods of treatment, improved staff-patient ratios, greater emphasis on prevention of mental illness, and the

support afforded new community-based facilities that provide out-patient treatment and post hospital follow-up care.

These changes have so substantially altered the operating procedures of public mental hospitals that it is no longer possible to base their financial needs on the number of beds occupied by patients. Many mental hospitals have been actively involved in the planning and delivery of community-based mental health services. For many public mental hospitals the treatment of inpatients is only one part in a continuum of services which have as their aim the management of patients in the community. Many have initiated pre-admission screening programs which have obviated the need for hospital treatment, while others have supervised discharged patients and thereby have greatly reduced the number who suffer a relapse.

These accomplishments are impressive. Yet when we view the decline in patient census in the face of a steadily growing number of admissions it becomes evident that more patients are in fact being served in these hospitals but are staying for a shorter time. This desirable result can come about only through intensive treatment, which calls for a staff larger and more skilled than that needed in custodial programs.

The demands of progress make it essential that the momentum already gained be continued. The evidence is ample that public mental hospitals are operating more effectively today than ever before in their history. The American Psychiatric Association urges all citizens with concern for the mentally ill and the mentally retarded to press for continued and increased support for these programs in order that this enlarged mission may be fulfilled.

At the recent APA meeting in Boston, North Carolina was honored by having several members elevated to Fellowship. They were as follows:

Frank Badrock (M-57)
Thad Jones Barringer (A-56; M-60)
John Iverson Boswell, Jr. (M-65)
Marianne S. Breslin (M-61)
David Franklin Freeman (A-54; M-62)
Frederick Roy Hine (M-56)
J. David Jones (M-63)
Demmie Gammon Mayfield (A-61; M-64)
Charles Willis Neville, Jr. (M-63)
John Thaddeus Monroe, Jr. (A-59; M-63)
John Brian Reckless (A-61; M-65)

Robert LeRoy Rollins, Jr. (A-59; M-65)
Nicholas E. Stratas (A-60; M-63)
Adriaan Verwoerdt (M-60)
Nakhleh P. Zarzar (A-59; M-64)

North Carolina has been honored by the appointment of two psychiatrists to chairmanships of American Psychiatric Association Committees. Dr. Ewald Busse was appointed Chairman of the APA Committee on Private Practice. Dr. Nicholas Stratas has been appointed Chairman of the APA's Committee on Psychiatry and Medical Practice.

Highlights of Meeting of Assembly of District Branches of APA
Somerset Hotel, Boston, Massachusetts

ASSEMBLY SPEAKER: John Adams—Chicago
May 12, 1968
2:00 — 10:00 p.m.

Statement by President-elect, Lawrence Kolb, New York: The APA will be called on for counsel and advice on many matters of national interest—such as aggression, hostility, mental health center activities, medicare, medicaid, etc.

The new APA constitution needs adoption without bickering about minor changes (it was adopted Tuesday, May 14).

Specialty groups need more effective representation in AMA. The APA may be called upon to elect delegates to AMA House of Delegates! A separate section on psychiatry may also be established, and the APA may be responsible for the programs of this section.

Statement of Speaker—Dr. Adams: Most officers of the APA now come from the ranks of past Assembly delegates and alternate delegates.

The committee on ethics is considering the APA position regarding responses to the Avant Garde magazine questionnaire on President Johnson's mental competence. Apparently a number of APA members *did* respond, four have been named, and correspondence with these has occurred. Essentially, these four have said that it is none of APA's business. There is question, however, whether this type of behavior on the part of a psychiatrist (i.e., diagnosis without examination) is a breach of ethics. This matter remains now only at the discussion stage in the ethics committee.

President Brosin arrived late with a brief but very pertinent statement. His remarks were around the topics of (a) information is power and (b) emerging new value system secondary to socio-

economic changes. Organizational design should not be a preoccupation when facts are not in. Relevant information needs to be gathered and distributed, not more information (witness the deluge of words out of NIH, APA central office, OEO, etc.). Socioeconomic changes brought on by governmental efforts to help keep up with social needs or correct some old sores in our society have made impact (for better or worse) into the American medical system. We, as physicians and psychiatrists, are sometimes called on to act before we know what to do. Often we are urged into being social activists, perhaps to the neglect of basic functions of doctors. District branches, or individual members, can be the most important points for the development of leaders to effect needed change within medical and psychiatric circles, as well as within the community at large, to meet needs which threaten our society.

New district branches were received into the fold, pending final action by Council. These are North Dakota, Ontario, and San Diego.

Highlights of Area reports: D.C. is fighting a psychologist licensing bill in Congress. A more liberal, and less defensive, position may be felt as emerging from the Assembly, although there are still a number of anti-psychologist die-hards.

In N. Y., any family of four with $5,300 (reduced from $6,000) income can qualify for Medicaid. A N. Y. DB has developed a statement, "What is a psychiatrist?"

Virginia psychiatrists are concerned about privileged communication problems arising from inquiries of agents or governmental investigative agencies without patient consent and without court order. These agencies (FBI, CIA, etc.) are to be contacted for discussion of this matter. Apparently some agents get argumentive and unpleasant when patient information is kept closed. Of course, all the psychiatrist has to do is say "no", unless patient permission is gained.

One hundred and seven members have recently been dropped from APA because of three years delinquency in dues. There are fewer and fewer APA members who are not members of district branches.

May 13, 1968 — 1-5 p.m.

Dr. Walter Barton emphasized Dr. Brosin's message with respect to need for district branch activity in developing leadership, providing counsel to the community (state and local), and building professional strength among psychiatrists.

APA now has a grant from NIMH to support a post-graduate education project for psychiatrists. Dr. Hugh Carmichael of Chicago has moved to Washington to head up this effort. A psychiatric knowledge examination for psychiatrists is being planned. Under this program a psychiatrist may take the examination for $10. Only he would receive the score. This method has been used successfully by the American College of Physicians. A detailed study of educational need among psychiatrists is to be carried out in one district branch, and Illinois has been selected for this.

A task force (new name for an ad hoc committee) in the Assembly has been formed to study "factors contributing to psychiatrists' optimum effectiveness in their medical societies." It is an old song that psychiatrists often do not, cannot, will not, or are not allowed to participate in medical society affairs. (Apparently, this applies less to N. C. than other states. Many N. C. psychiatrists are active in local medical societies. However, restriction is put on state medical society activity simply because of conflict in annual meeting time.)

Dr. Levensohn of NIMH reported that 300 mental health centers have been funded with federal funds. Total financing includes 35% federal, 40% state and local and 25% private or third party participation. Seventy five percent of centers include a general hospital. There is generally a lack of involvement of private practitioners of psychiatry in center planning and operations. (This is not true in N. C. Where there are private psychiatrists, there involvement has been considerable.)

Dr. Lucy Ozarin, also of NIMH, presented the federal perspective after four years of center program initiation. Concern was expressed by delegates about governmental intrusion. Defensiveness on the part of psychiatrists might well be replaced by active involvement of individual psychiatrists and DB officials in center developments on local and state level, exerting an influence on friends, families, politicians, and agencies to do right.

Perry Talkington, Texas, was elected Speaker-elect, a mark for the South!

Charles R. Vernon, M. D.
Alternate Delegate

GIST OF THE MEETING OF A.P.A. COMMITTEE ON PRIVATE PRACTICE May 15, 1968

This standing committee is being abandoned to be replaced by an ad hoc committee (called "task force") to study private practice issues. Our own Dr. Ewald Busse will be this task force leader.

One practitioner described a private group in Omaha, Neb. comprised of seven psychiatrists and seven non-psychiatrist therapists which provides a wide variety of clinical services to all citizens, more and more paid for by third parties — a real private mental health center.

Getting consultative, educational, and program planning time from private psychiatrists is still difficult and more private enterprise efforts need to be put into these functions.

There is a trend toward calling it "private enterprise" rather than "private practice" since the latter connotes only traditional patient services, and private enterprise intimates the psychiatrist being just that — i.e., enterprising in providing services according to demand but on a contractual or fee for service basis.

Although there is a trend toward physicians of all sorts being on salary, there is also a trend toward physicians developing new ways to deliver their goods on a private basis.

We are looking forward to Dr. Busse's task force giving us some answers — or at least asking some relevant questions about this subject.

UNIVERSITY OF NORTH CAROLINA

MSPH in Mental Health Statistics

The Biostatistics Department of the University of North Carolina School of Public Health is now accepting student applications for September, 1969 admission to its training program in mental health statistics. This program is designed to prepare statisticians at the master's degree level for positions in the field of mental health.

The program leads to a Master of Science in Public Health (MSPH) degree in Biostatistics. The course content of the program includes the regular statistics courses for the MSPH and MPH in Biostatistics, augmented by courses which discuss the specific statistical problems in the mental health field. The program lasts eleven months and consists of two academic semesters followed by a ten week field training experience during the summer in some mental health agency.

Applicants should have undergraduate work in either mathematics, statistics, psychology, sociology, or biology. Calculus is recommended. No prior experience in public health and or mental health is required.

NIMH fellowships are available to qualified applicants. These carry a tax-exempt stipend of $2400, $3000, or $3600, depending upon prior work experience in the field.

Requests for more information and admission forms should be sent to:

Dr. Donna B. Ruhl
Department of Biostatistics
School of Public Health
University of North Carolina
Chapel Hill, North Carolina 27514

MEDICAL SOCIETY OF THE STATE OF NORTH CAROLINA

Dr. David G. Welton was installed as President of the Medical Society of the State of North Carolina at the Society's 114th Annual Meeting, May 11-15, 1968 held in Pinehurst, N.C. Other new officers include Edgar T. Beddingfield Jr., M.D., Wilson, N.C., President-Elect; John Glasson, M.D., Durham, N.C., First-Vice President; Mark McDonald Lindsey, M.D., Hamlet, N.C., Second Vice-President.

Immediately following taking over the duties of President Dr. Welton appointed the new committees. Serving as Chairman of the Mental Health Committee for 1968-1969 is John L. McCain, M.D., Wilson, N.C. The Subcommittee on Mental Health Education will be chaired by Dr. Charles R. Vernon, Wilmington, N.C. Dr. Lloyd J. Thompson, Chapel Hill, N.C. is Chairman of the Subcommittee on Mental Retardation and Children's Services and Dr. Donald E. MacDonald, Charlotte, N.C., is chairman of the Subcommittee on Alcoholism.

The Subcommittees plan to hold their meetings in August and the Mental Health Committee will meet at the Committee Conclave scheduled for September 25-29, 1968 at the Mid Pines Club, Southern Pines, N.C.

The Society also announces the services of a Field Representative, Mr. Dan Mainer, who will be working closely with county medical societies.

Notice to Contributors

Manuscripts and editorial comments should be addressed to the Editor-in-Chief, N. C. Department of Mental Health, P. O. Box 9494, Raleigh, N. C. 27603.

Contributors need not be psychiatrists, neurologists or M.D.'s but should be involved in some aspects of program, whether clinical, educational, or research, pertinent to mental health or mental illness.

Manuscripts offered for publication should be submitted in the original, typed on bond paper and double spaced with 70 characters per line. Footnotes, bibliographical references, quotations, etc., should also be double spaced and the use of footnotes minimized.

References to books and journals should be numbered consecutively in a bibliography at the end in the order in which they appear in the manuscript. References should be limited to those used by the author in the preparation of the article and kept to a minimum.

The author's privilege of correcting galley proofs may apply only to printer's errors.

Tabular material, drawings and charts should be submitted on separate sheets, clearly marked as to where they are to appear in the text.

Vol. III, No. 3 1969

NORTH CAROLINA

JOURNAL OF MENTAL HEALTH

NORTH CAROLINA JOURNAL OF MENTAL HEALTH

Published by
The State Department of Mental Health
in conjunction with the
N. C. Neuropsychiatric Association

NORTH CAROLINA JOURNAL OF
MENTAL HEALTH

Volume 3 Number 3

1968

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NORTH CAROLINA JOURNAL OF MENTAL HEALTH
is published quarterly, Spring, Summer, Fall and Winter.

It is a scientific journal directed to the professional disciplines engaged in care, treatment, and rehabilitation of mentally ill and retarded patients as well as to those engaged in professional research and preventive work in the field.

This journal is intended to be inclusive rather than exclusive and is not meant to be regarded as simply a house organ of the North Carolina State Department of Mental Health.

It is hoped that the journal will reflect the broad-based philosophy of psychiatry current and will draw on areas reflecting the total spectrum of psychiatric and neurologic thought, program and research.

Subscription may be obtained by writing the Editorial Offices, North Carolina Department of Mental Health, P. O. Box 9494, Raleigh, North Carolina 27603.

(Notice to contributors—see inner back cover)

EDITORIAL

What Priority for Mental Health Programs?

Professionals usually assume that a good mental health system should provide a full range of services. Even though statistical proof may be lacking, most people in the field of mental health have a conviction or take it on faith that our efforts are worthwhile. We also aim for effective as well as comprehensive programs.

In the instance of alcoholism, it is not enough to have state hospitals, clinics, and education. These programs must be organized so as to provide a full range of services and continuity of care. Prevention through education, local detoxification, coordination of community services, out-patient treatment and psychiatric hospitalization have to be put together in a system that deals with all alcoholics. Priorities for development of different phases of this system have to be set in terms of available funds, personnel, and community support, and the entire program must compete with other projects. Most of us would accept all this and even be willing for our operation to be examined for efficiency, effectiveness, and economy.

Professionals also usually argue rather convincingly that mental health programs should be continually expanded and improved. Seemingly, there is always a need for more and better services to increased numbers of people. The assumption that mental health should get more money also implies two other assumptions—that some other program gets less or that the total funds available are increased. We often overlook

or do not feel responsible for these latter items. Most state budgets and tax structures are set by some combination of legislative opinions, administration platforms, departmental campaigns, various lobbies, financial reality, and public opinion. Successful mental health program directors seek to design effective programs, develop popular support, and influence the decision makers who appropriate funds. Do we fall short of our responsibility by looking only at mental health needs? How do the goals, objectives, and priorities of different agencies mesh?

An area might seek a highway without considering the possible long-range results of new industry, urbanization, culture conflicts, and population mobility. Some urban renewal programs have produced unexpected mental health problems secondary to population relocation and alteration of community patterns. New jobs may absorb those caring for elderly people at home and necessitate geriatric programs. Population shifts change patterns of medical care. Mental health needs are affected by programs of other state agencies; conversely, construction of a mental health facility may decrease the number of nurses or social workers available to other programs or change the local salary structure.

Should the needs of children be considered separately by many agencies with different goals? Decisions are made somehow on the relative priority of school lunches, prenatal care, psychotic children, high school dropouts, remedial reading, and physical education.

These examples suggest the complexities of planning, organizing, staffing, directing, and controlling multiple programs which are funded from one over-all budget. If programs are linked in a system designed to achieve major goals, need, feasibility, and priority are more easily determined. The major benefit of the system's concept, however, is improved cost effectiveness.

Using these concepts a program budget would include goals, objectives, timetables, and alternatives. In some cases additional law enforcement services or sanitation inspectors would be more valuable to an area than additional psychiatric consultation. Although an area might be able to use additional mental health personnel effectively, the more pressing need might be highway safety or vocational training.

Mental Health should be part of a system of services that meet the needs of people within the limits of available funds and statewide goals. The systems concept allows for the most economical and comprehensive approach to problems. Obtaining legislative appropriations on the basis of selling a program leaves something to be desired if more significant programs are bypassed. Mental health funding should not be sought for its own sake, but rather as part of a state plan to use available resources to meet human needs.

R. L. Rollins, Jr., M. D.
Superintendent
Dorothea Dix Hospital
Raleigh, North Carolina
Associate Regional Deputy
N. C. Department of Mental Health

NORTH CAROLINA DEPARTMENT OF MENTAL HEALTH: GOALS, FUNCTIONS AND PROBLEMS

Eugene A. Hargrove, M.D.
Commissioner of Mental Health

In order to understand the goals, functions and problems of the Department of Mental Health, we need to talk briefly about the rapidly changing scope and focus of mental health problems in North Carolina and throughout the country.

It wasn't long ago when our chief concern was for the very sick individuals—the psychotic patients. Because there were no other resources to care for these persons, the majority were placed in large institutions, surrounded by high walls, where they received custodial care. Many remained within these walls for the rest of their lives.

By and large, the same was true of the mentally retarded. They were either kept out of sight within the confines of their homes or they were sent to large custodial institutions.

But over the years, as we have learned more about human behavior, we have found that there are people who are not sick enough to be in institutions, but who are incapacitated to some extent because of their symptoms of anxieties or phobias, depressions or delusions.

We have found that there are persons with character disorders who have a hard time adjusting to life, and who make things very difficult for themselves and those around them. These persons frequently cause social unrest and disorder either in their immediate environment or in other areas. The juvenile and adult delinquent and the alcoholic are examples of this group.

In our learning process we have discovered that there are many mental health problems, such as alcoholism, schizophrenia and mental retardation, among welfare recipients.

We have discovered that one in every ten school-age children has a mental or emotional handicap. This calls for early case detection and early treatment to prevent more serious difficulties from developing later on.

I think it is important to bring these out because they illustrate how the scope of our problems and concerns has broadened in recent years.

For example, during the 1966-67 fiscal year, we treated a total of 57,270 mentally ill, retarded and alcoholic patients in our psychiatric hospitals, retardation centers, community mental health programs and the alcoholic rehabilitation center. Of these 29,071 received help at the community level; 22,779 in our hospitals; 4,882 in the retardation centers and 538 at the alcoholic rehabilitation center.

The rate of admissions to our four state psychiatric hospitals is increasing, but our discharge rate is increasing even more and the average daily resident population has been reduced. We believe the more intensive treatment and rehabilitation programs which we are now providing are a key factor in producing this turnover in our patient population. While it is costing us more today to provide more intensive care for our increasing admissions, we feel in the long run we will realize a substantial savings of personnel time and of money for additional facilities.

What we eventually hope to accomplish here in North Carolina is the development of a statewide mental health program which will help reduce the amount of mental and emotional handicaps, including mental illness, retardation and alcoholism.

To achieve this goal, we must continually test and monitor our mental health programs, particularly our new programs, to insure the highest quality of care for our patients with the greatest efficiency and economy.

Means by Which We Carry Out Our System of Care

In order to highlight the ways by which mental health care is carried out, we will emphasize four areas: our organizational structure, our facilities, our personnel and our programs.

Our department operates under the Board of Mental Health which is appointed by the Governor. Both the Commissioner and General Business Manager are responsible to the Board.

We are fortunate to have Board members whose energy, intelligence and interest have enabled them to support essential as-

pects of our programming, and who have served the state well as representatives of the people of North Carolina.

Our Raleigh office is organized into a number of divisions and staff services with responsibilities for program planning and evaluation, public relations, statistics and others. The heads of these divisions are directly responsible to the Commissioner and General Business Manager.

In addition, we have four regional deputy commissioners and a deputy commissioner in charge of mental retardation and children's programs. Each regional deputy is responsible for overseeing and developing mental health programming and facilities in one of our four geographic regions.

We have divided the state into four geographic regions in order to focus better on the community. Patients are admitted to the psychiatric hospital or retardation center serving their region, and are treated in geographic hospital units serving their county of residence. We can think of these geographic units as smaller hospitals within the larger parent institution. The unit system of hospital administration was initiated several years ago as a means of bringing the hospital and communities it serves closer together to provide a broader range of mental health services for all citizens.

We have further subdivided each of the four regions into mental health program areas, in which we now have, or plan to establish, mental health services in conjunction with communities.

In each of these areas the geographic hospital unit and the retardation center that serve the area, the community-based mental health program and other helping resources join together in meeting the needs of the counties in the area.

As a way of illustration, let's look at the western region and the program area served by the New River Mental Health Center in Boone. The center serves Ashe, Alleghany, Wilkes and Watauga counties. The clinical director of the community mental health program, who is a psychiatrist, is also director of Unit C at Broughton Hospital in Morganton, the unit which serves the four-county area I just mentioned. By having one director for both hospital unit and community mental health program, we can more effectively coordinate our services, particularly in providing continuity of care.

Let me cite a specific example. The director and other staff

members might see a patient in the community mental health center and decide the patient needs hospitalization in Unit C. He would then see the patient during his hospital stay and continue follow-up care with the patient when he is discharged. As part of the treatment team, the social worker, the psychologist, the mental health nurse and other staff members from the community center all work to provide continuity of care for the patient.

It works the other way around, too. The treatment team from Unit C goes out of the confines of the institution to work with community personnel in developing patient services of many kinds.

The New River Mental Health Center also has an excellent relationship with Western Carolina Center in Morganton and plans are being made for staff members of the retardation center to work with parents of disturbed children in the community.

This example illustrates the ways in which our structure allows us to carry out our system of care with particular focus on community-based services.

Another means by which we carry out our overall system of care is through our facilities. We have approximately 15,000 beds—half of all the hospital beds in North Carolina—in our four psychiatric hospitals, four centers for retarded and the alcoholic rehabilitation center at Butner. In addition, we operate forty-two full and part-time community mental health clinics in partnership with communities across the state, and special treatment programs in various facilities.

In order to carry out an effective system of care, and to ease the personnel shortage we are now experiencing, we are going to have to step up our efforts in the area of manpower development.

One thing we can do is provide additional supporting personnel to free our professional staff involved in patient care from many time-consuming tasks which take them away from the patients. For example, if we had additional housekeeping personnel they could perform duties that many of our nurses and psychiatric aides must do, by necessity. This would enable them to spend more time with our patients. Likewise, additional ward clerks could relieve our aides and nurses of much of the paperwork that is a necessary part of hospital operations.

The current demand for nurses, physicians, psychologists, social workers and other professionals far exceeds our supply, and

we need to expand our training programs to help combat this shortage. Our psychiatric residency training programs at Dorothea Dix and John Umstead hospitals; our university-affiliated programs and liaisons with institutions that are training professionals in health-related fields; our child psychiatry training programs; and our inservice and continuing education programs all need to be expanded. The provision of attractive teaching and training programs for social work students, for university interns and others, will help us in our efforts to recruit skilled mental health workers to join with us in carrying out our system of care.

All of our training programs contribute a great deal toward providing better overall care for our patients through helping to keep our personnel up-to-date on new and better treatment and rehabilitation techniques. And all play a part in improving the morale of our staff which is vital to carrying out an effective program. We have endeavored to improve the morale of our employees by encouraging staff initiative and participation; promoting the team concept of everyone's working together toward a common goal; creating working committees and other communication structures at all levels; and defining areas of authority and responsibility.

The addition of personnel officers to the staffs of all our residential facilities has proved to be an excellent step toward improving employee morale, for now our employees have someone who can help them with their problems.

In addition to providing more supporting personnel and expanding our training programs, we need to step up our recruitment efforts and figure out some ways to ease the problems in this area.

Our rapidly changing field is generating the need for specialists with new skills who are currently in short supply and who will be for some time to come. Add to this the problem of inadequate salaries and we have the crux of our recruiting problems.

To expand our pool of mental health workers, we are working to train needed employees with special skills. One of the programs in which we're involved is the Mental Health Assistant Program, initiated in conjunction with several of the state's community colleges. Students participating in this two-year program receive an associate in arts degree and may be employed in our state mental health facilities after graduation.

The department has also established a standing committee on

new mental health careers to develop new positions, especially at the semi-professional and sub-professionals levels. This committee will maintain liaison with training institutions, assist in curriculum planning and will involve departmental facilities in training.

Our principle organized effort to interest young people in the work of the department is the Summer Experience in Health Careers Program. This summer thirty-four outstanding senior high school students will participate in this program as apprentice staff members in a variety of departmental units.

In the next biennium we will place emphasis on improving and expanding programs and services to children and adults in their communities with less emphasis on facility construction.

Our forty-two community mental health clinics, which we operate in conjunction with communities across the state, are providing mental health services to people in 73 of our 100 counties. Some of these facilities operate only part-time—several days a week—while others have full-time staff and offer a variety of services.

There are a number of communities that have moved further ahead and are planning the development of comprehensive community mental health programs to serve their program areas. The eleven areas which currently have comprehensive programs underway or in advanced planning stages, and which have received federal and state funding, are:

Area 1 Jackson-Haywood-Swain-Macon-Clay-Graham-Cherokee
Area 8 Mecklenburg
Area 13 Alamance-Caswell
Area 20 Moore-Hoke-Richmond-Montgomery
Area 25 Wake
Area 23 Lee-Harnett
Area 22 Cumberland
Area 21 Robeson-Bladen-Columbus-Scotland
Area 31 Halifax
Area 24 Johnston
Area 29 Wilson-Greene

There are additional areas which anticipate having comprehensive community mental health programs underway in the next biennium. These include:

Area 2 Buncombe-Madison-Yancey-Mitchell
Area 3 Avery-Watauga-Ashe-Alleghany-Wilkes
Area 5 Burke-Caldwell-Alexander-McDowell
Area 11 Forsyth-Stokes
Area 12 Guilford-Rockingham
Area 14 Orange-Person-Chatham
Area 15 Durham
Area 30 Nash-Edgecombe
Area 28 Wayne-Sampson-Duplin
Area 35 Pitt-Martin
Area 27 New Hanover-Brunswick-Pender

Each of these programs will have all the components required for comprehensive mental health programs. These include the following:

First, *consultation and education* to lay and professional groups in the community. This is a means of reaching more people in need of help and is particularly important because of the limited number of professional personnel in our community programs. By necessity, we are getting away from the traditional one-to-one concept of psychotherapy, and even the group psychotherapy treatment model, and are having to reach out and embrace caretakers in the community to help us with our tasks.

Secondly, our comprehensive programs will provide *screening and diagnosis and continuing care* for those who need it.

The third service our comprehensive programs will provide is *partial hospitalization* either during the day or in the evening. Some patients do not need full-time hospitalization and can benefit from treatment and rehabilitation programs provided for a few hours a day at the mental health center. The working man, for example, may come to the center in the evening for treatment, while the housewife may come during the day and be at home with her family in the evening.

Fourthly, the community programs will offer *inpatient* and *outpatient* services. Some patients require longer, more intensive treatment in a hospital or other inpatient facility while others benefit from outpatient services provided during periodic visits to the mental health center or other community resources.

Twenty-four-hour-a-day emergency care is the fifth service provided by the comprehensive programs. Emergency service provided around-the-clock by psychiatrists and other helping persons

will make help available for persons in crisis situations who need help on the spur-of-the-moment.

Our comprehensive community mental health programs will work with communities to provide help for children, adults and our aged citizens. In connection with the latter, I would like to mention that a strengthening of the Governor's Council on Aging would lend needed support to this problem of geriatrics.

The development of community mental health services will call for increased coordination between community agencies such as schools, health and welfare agencies and our mental health facilities, including the geographic units of our hospitals. By uniting our efforts, we can plan and carry out more effective programs of prevention, consultation, and education, treatment and rehabilitation.

There will be significant increased emphasis on community services for the mentally retarded in the next biennium. For a long time we have looked for more effective ways to strengthen the ties between the four large centers for mentally retarded children and community services. The 1967 legislature enacted legislation to establish two community mental retardation complexes to be located in Mecklenburg and Guilford counties. These facilities will provide a multiservice program including day care, residential care, sheltered workshops, vocational training and home service. Children admitted into these programs will be thoroughly evaluated by an interdisciplinary team. Home service will include visits by social workers, nurses and other service-oriented personnel.

The 1967 legislature also provided for grant-in-aid payments to day care, residential facilities and sheltered workshops for the moderately and severely retarded child. As a result of these residential and day care programs, many children will be able to receive care at the local level.

We also anticipate the development of foster family care, small group care and other kinds of placement services in the next two years.

There are far too few resources, both on the state and local level, to provide adequate services for our retarded and emotionally handicapped children, and in the years to come I think we will see the need for a greater percentage of appropriations in this area.

At the present time, we are focusing our efforts on prevention, early diagnosis and treatment in the community with the aim of helping parents, teachers and other helping professions become more competent in recognizing and dealing with mental and emotional problems.

What we will do in the upcoming biennium is concentrate primarily on working with communities across the state in developing short-term treatment programs, more family counseling services, and helping schools and other community agencies to better serve mentally retarded and emotionally handicapped children.

Our psychiatric hospitals have only a few specialized treatment units for children and our retardation centers have long waiting lists. At latest count, there were 677 awaiting admission to these facilities. We have recently added facilities at Western Carolina Center that will provide 310 more beds, and we have added space at the other retardation centers within the past year or two, but space is still scarce, particularly for severely handicapped individuals.

One of the most important program areas to which we will direct attention in the coming biennium is alcoholism.

Because of increased efforts in education, society's view of the alcoholic has changed in recent years and the stigma that was so evident in years past is gradually diminishing. More people are viewing the alcoholic as a sick individual in need of help, and, consequently, more alcoholics are seeking treatment for their illness in our state mental health facilities. Our psychiatric hospitals, particularly, are feeling the effects of these changes where one in every three admissions is for alcoholism.

More and better care for our alcoholic patients is being demanded and we are hard pressed to provide sufficient facilities and personnel to meet these demands. Although we will be opening two new alcoholic rehabilitation centers in Greenville and Black Mountain next year, and are requesting funds in our "B" Budget for a rehabilitation center at Dorothea Dix Hospital, we cannot expect these facilities to bear the full load.

We need to strengthen the existing alcoholism units in our psychiatric hospitals and in the prison units in local communities. We need to make treatment and rehabilitation services for the alcoholic and his family an integral part of our comprehensive

community mental health programs. And we need to work with community alcoholism programs across the state in developing local resources and coordinating activities.

In recent years, our state psychiatric hospitals have branched out to provide a wide range of services for a patient population with many kinds of mental health problems. With increased emphasis on hospital-community collaboration and the team approach to the treatment of mental and emotional disorders, we are providing today's patient with a therapeutic milieu of broad proportions.

In addition to working with communities to implement a continuum of care for our patients, our hospitals are carrying out special treatment programs for children and adolescents and are working in such areas as forensic psychiatry and vocational rehabilitation, among many others. In the future, they will gradually become more decentralized as they make the transition to becoming regional resources—back-up facilities for treating community mental health problems. For example, the hospital will provide supportive services for geriatric patients from a specific program area if sufficient local resources are not available to meet the need.

We have long realized the importance of testing the efficiency of our mental health programs, as this is the key to carrying out an effective system of mental health care. But limited resources have restricted what we have been able to accomplish in this important area. We are, however, applying modern management methods to our continuing study of hospital administration so that the efficiency of our statewide operation can be increased with a minimum increase of funding.

We believe that it is important for our young psychologists, psychiatric residents and other professionals to have some opportunity to participate in our research and evaluation programs. This will enable them to receive feedback about the quality of their work, a source of much satisfaction to them.

In the fields of alcoholism, mental illness and retardation, it is the job of the research scientist to monitor the effectiveness of our therapeutic procedures. As per diem costs of hospitalization rise, I think we can see the obvious benefits of developing better methods of treatment to shorten the hospital stay of many of our patients.

There is a small, but outstanding, research project currently being conducted at Western Carolina Center. At the Morganton facility, researchers are performing genetic studies on Mongoloid children and their families, trying to pin down unusual chemical and hereditary abnormalities among Mongoloids. These studies may make it possible for parents of these handicapped children to know their chances of having additional Mongoloid youngsters in the future, and may result in more effective treatment and rehabilitation of these children.

In the coming biennium we are proposing the creation of a research facility at Dorothea Dix Hospital so that we can more effectively coordinate and consolidate research and evaluation programs throughout the department. This facility will offer services for data processing, fund clinical research programs and provide consultation services to personnel throughout the system.

There are a number of problems which are confronting us at the present time and others we can envision as developing in the future.

A key problem is how to recruit well-qualified professionals and sub-professionals with the salaries that are now offered for many positions. For example, we are faced with a critical problem in employing and keeping male psychiatric aides. We are going to have to take steps in the immediate future to upgrade these important positions or our patients are going to suffer. The labor market is highly competitive and these key workers are being lost to other state agencies and private businesses. The salaries being paid our business personnel are unrealistic and we need to upgrade these classifications also.

Determining our role in working with other agencies to provide services is another problem. For example, we have enjoyed a good relationship with the Department of Corrections for the past five years. For quite some time our staff members have worked in the mental health clinic and the hospital at Central Prison. We have worked with the Department of Corrections as consultants, helping them to apply mental health principles which might provide solutions to problems that develop from time to time.

While we have been able to offer some assistance to the Department of Corrections in providing medical and psychiatric care for prisoners, we are not able to shoulder this responsibility entirely. The provision of medical care for the prison population is an area of statewide concern, one to which considerable study

should be devoted, and one where the support of other state agencies and private medical groups is needed.

Study must also be given to whether it is the responsibility of the Department of Mental Health or Department of Public Instruction to organize the educational curriculum in our state mental retardation centers.

As our programs expand in the future there will be an increasing need for better travel arrangements and communications, particularly as we place more emphasis on developing hospital-community ties and implementing our area directorship concept.

We need to devise guidelines for working with other service agencies on the state level toward establishing common multi-county groupings for administration of programs. Some progress has been made with the Division of Vocational Rehabilitation and we are working with Health and Welfare, as well.

On the horizon we envision a growing problem with the narcotic addict. We must begin planning now as to the best way to provide for this population group and hopefully, to prevent this from becoming a problem.

There are several statewide organizational improvements in our area of concern which we would like to mention.

It would be appropriate at this time, we feel, to set up a study committee to look into the implications of Comprehensive Health Planning, Areawide Health Planning and related activities. Perhaps a legislative study committee should be appointed to undertake this task. We feel that a definite stand taken by the Legislature regarding the degree of authority and responsibility of these two related activities would be very helpful and would tend to reduce the many conflicting expectations which are being raised at the community level in regard to these planning programs. Or, perhaps the Advisory Council of Comprehensive Health Planning should sponsor this undertaking and invite a number of legislators, personnel from the Institute of Government and other appropriate persons to help them with this task.

We might also consider strengthening the Governor's Planning Task Force under the Department of Administration to include bolstering of planning efforts in other human resource areas besides health, such as education and welfare, for example.

We feel the need for providing the heads of state agencies with increased authority and responsibility for personnel matters and

the expenditure of appropriated funds, and would support any move in this direction.

In looking to the future, we want to encourage North Carolina's participation in the federally-sponsored Title 19 program which shares between the federal, state and county governments the costs of medical care for the needy.

Although we would not recommend a statewide reorganization to create a Health, Education and Welfare agency following the federal model, we do believe, however, that the area of cooperative programming in which we are currently engaged can provide the positive aspects of the federal model without its restrictions.

In order to accomplish our goals of helping to reduce the prevalence and the incidence of mental and emotional handicaps in North Carolina and to increase mental health, we are going to have to work more in the area of education and prevention. We are going to have to rely on the continuing support of many groups and agencies both on the state and local level.

We are going to need support from our state legislators, and, most of all, from the people of North Carolina, for it is in the communities of our state where the mental health problems must be recognized and dealt with in their early stages if more serious problems are to be prevented.

MODERN SYSTEMS THEORY—A STRATEGY FOR MENTAL HEALTH

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Decision-makers at all levels in mental health programs, including hospital administrators, clinicians, planners, coordinators, and state commissioners are becoming increasingly aware of the complex tasks they face. To effectively cope with such complexity new conceptual models, new styles of thought, new decision tools are required. Systems theory offers a new strategy for the behavioral sciences which is particularly relevant to mental health. The decision-maker is provided with new conceptual schemes for the analysis, direction, and improvement of the formal organizations which administer mental health efforts such as clinics, hospitals, or state or regional programs, and of the informal social structure of which mental health problems are a part.

The purpose of this paper is to (1) review how general systems theory can be a viable strategy for mental health programs, (2) outline a tentative conceptual scheme which might provide the basis for such an effort, and (3) suggest phases of implementation.

I. Basic System Concepts

A *system* is most generally defined as a set of elements or parts which have definable organization of interrelationships. Systems theory operates independently of any discipline or content area, for it is a philosophy of science or a way of looking at the world. Therefore, one is able to consider the interaction existing between mechanical, physical, or social elements, and therefore focus on any relations which may exist between parts of a system including energy linkage, as between parts of a combustion engine, and information linkage, as between parts of a social organization.

As a system moves from a relatively fixed, mechanistic structure to a more adaptive, feedback structure, it becomes less a closed system and more an open system. A *closed system* is one which operates with fixed relationships requiring little or no outside

intervention, and it tends to lose its essential organization if disturbed. An *open system* interacts with its environment as an essential part of survival.

One can also consider *morphostatic systems,* those which maintain their given form or organization, and *morphogenic systems,* those which change their form or organization. Open systems are not necessarily morphogenic, for the ability to obtain information from the environment does not necessarily mean the system can change its form accordingly. A heating system controlled by a thermostat is an open morphostatic system designed to maintain a given temperature level, something the system can not alter. Feedback if used only to maintain a given structure or balance. An open, morphogenic system, on the other hand, is able to evolve into new forms.

II. Mental Health Applications

Certain assumptions on which this paper is based must be noted. First, any social organization including those within the mental health domain can be analyzed in terms of its "systemness" or its ability to function as an open, morphogenic system. Second, such organizations can be purposeful if they are directed toward certain goals which are defined or are capable of being defined. It is, therefore, essential that we focus upon objectives or goals first and then determine which activities (system behavior) are necessary or best able to meet these goals.

Third, mental health programs are by their nature large (contain a great number of elements); complex (made up of many connections, relations, or interactions among these elements), and dynamic (subject to change or movement over time). If we accept this assumption, we can not consider our organizations as simple, fixed structures. The population to be served is constantly changing; the activities designed to meet their mental health needs must also change.

Fourth, one especially meaningful way to cope with and manage these large and complex phenomena is through the use of systems theory to develop operational models and other schemes which have a firm base of formal theory, are capable of being empirically verified, i.e., are useful, and are sufficiently reliable to permit effective management.

Note there is no assumption that existing programs or structures are by definition "systems". In common practice anything in mental health which seems extremely complex and difficult to define is called a "system" which is mainly an indication of our ignorance or uncertainty about the phenomenon. If a phenomenon is unknowable and undefinable how can it be called a system? I often wonder what "*the* mental health system" is. Rather our concern should be with identifiable sets of relationships which can be considered purposeful and goal-directed such as a system to provide care or a system to identify and refer serious social deviance.

Purposefulness requires continuous interaction between the system and its environment. This suggests a need for *input*, that which enters from outside the system, and *output*, that which goes from the system to its environment. Input takes a variety of energy forms, depending upon the type of system under consideration such as time, money, effort, supplies, people, or information. Output results from action of the system utilizing its input. The organizing nature or form of a system is its structure or the relationships between components. The *goals* of a system are its purpose for existence or what it seeks to accomplish.

As an example of how these concepts could be applied to mental health organization, Dupont (2) has developed the following table which contains suggested mental health counterparts to system concepts:

1. System	= Total program
2. Sub-system	= Sub-program
3. Sub-system structure	= Program organization
4. System purpose	= Program objectives
5. System boundaries	= Population-to-be-served
6. System input	= Program input (personnel, funds, services, treatment methods)
7. System output	= Programming output (services rendered and change in population served)

This is but one of many ways to look at mental health organizations with system theory.*

In mental health goals are absolutely necessary to permit continuous evaluation, that is, a determination of goal achievement or unachievement. It is one thing to state general goals such as "to prevent mental illness" or "to maintain a responsiveness to public needs," or "to restore the mentally ill to self-dependence and optimimum well being." Such goals are more directional than operational.

One position taken by this paper is that mental health goals must be as operational as possible, such that quantitative indices can be developed. For example, it is one thing to say "our goal is to prevent alcoholism"; it is quite another thing to say "we wish to reduce the incidence of alcoholism in a year by 25 per cent for the current population". (However, I would hope mental health goals are more creative than this example.)

Our goals must also not be confused with methods devised to achieve these goals. Unfortunately, such has often been the case when mental health becomes so concerned with continued development or maintenance of a given service or treatment modality that the reason (goal) behind it becomes lost. Obviously, if a general goal is to prevent or reduce alcoholism, a sub-goal might well be concerned with optimal programs to achieve a higher level goal.

Figure 1 is a flow graph of a viable or open, morphogenic system. The behavior of the system is its interaction (output) with the environment, and the system may well be designed to change or modify the environment. These activities will produce a response in the environment; no response is a possible one.

As an example a sub-program of a total mental health organization may define a goal of reducing the number of identified alcoholics in a given region of the state. To make this goal more

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* An interesting point in this listing is Dupont's definition of the population as the *boundary* and *not as input* which is the popular conceptualization of patients. A consideration of patients as a part of the system rather than raw material to be operated upon by the system is a unique characterization of a mental health organization and enables the organization to define its relationship to society in much more meaningful terms.

To define the system boundaries by the formal organizations which make-up mental health programs is to entirely miss the overall organizing nature of the system and focus only on physical things which bear little resemblance to the actual operating system.

operational it may be determined after some investigation that a drop of 15% in proportion to regional population would be significant. A new program of early identification and treatment of alcoholics in the region is inaugurated.[c]

After a period of time, information about alcoholic pattern begins to flow in. If it is determined that the goal is being reached, namely a change which represents a decrease equal to or in excess of 15% then existing activities can be continued. If such a decrease is not observed then decisions must be made to bring the system back in line with goal-direction. One may determine that 15% is an excessively large goal, and that it must be reset to a lower level. Then we may again ask if the system is achieving its newly defined goal. If the answer is "yes" then the process can continue. If "no" then questions about the program(s) designed to reduce alcoholism in the region may be raised.[c]

Through such a continuous process of evaluation of goals and activities and modification of system behavior, the main thrust is placed on serving the population rather than on activities or programs which *might* be initiated or sustained. Primary questions would concern the mental health needs of communities; secondary questions would include the types of programs needed to meet these needs. This enables the system to be sensitive to the environment and thus change as the environment changes.

III. The Value of Systems Theory to Mental Health Organizations

In any discussion of systems it is possible to speak of *optimal behavior*, i.e., "best possible" behavior of the system utilizing

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[c] It should be noted here that many variables other than those introduced by a new program may well influence any observed changes in the alcoholic population, and such potential variables should be given consideration in the overall evaluation of the system. Extraneous variables, i.e., those outside the sub-system, might be the critical ones in determining the success or non-success of the new program. However, in this example let us assume that such variables are generally constant and we can accurately believe that any changes in regional alcoholism can be attributed to our own particular efforts.

[c] In reality the prevention and treatment of alcoholism most certainly would involve a series of indicators for a more comprehensive set of goals than those stated in this example. It may well be that the interaction of a large number of indices must be considered to determine the degree of goal-achievement.

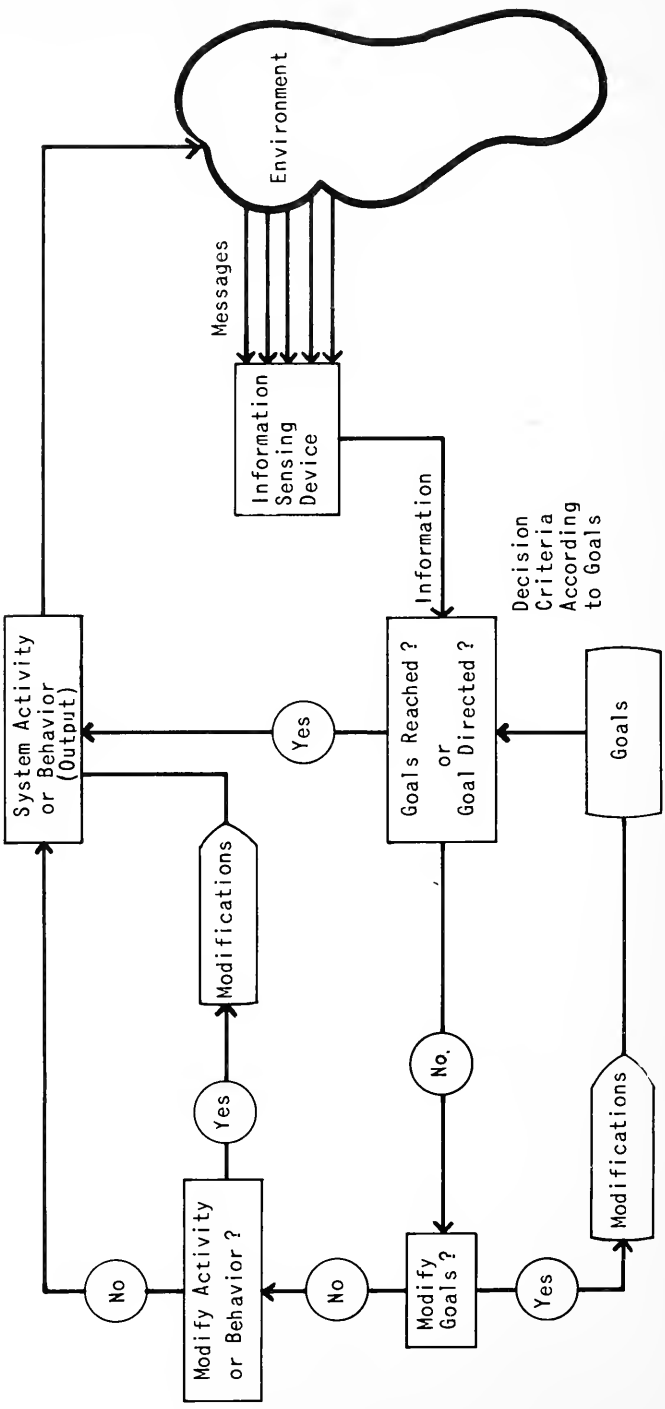

FIGURE 1
Flow Diagram of a Viable System

available resources, relevant to its goals. A system can be described in terms of its ability to achieve optimization or be most efficient. This means a system is achieving its goals with the least energy expended, which in mental health might include money, people, effort, facilities, supplies and time.

One way of describing the efficiency of a mental health system is in terms of its variability around its level of optimization. This might be characterized in a graph in which a horizontal line is drawn representing "level of optimization". The area above and below the line represents activity on the part of the system which is sub-optimal, i.e., less than most efficient, relevant to stated goals. Above the line is excessive or unnecessary activity and below is insufficient or inadequate activity. Measures of the actual efficiency of a system could be plotted on the graph and the resulting curve for most any mental health system probably would produce an extremely variable curve, sometimes well above and sometimes well below the line of optimization.

At the top of the graph one might imagine a dotted line called "the upper limit of tolerated variation" and at the bottom a second called "the lower limit of tolerated variation" which represent the amount of variation from optimization tolerated by the society or more accurately state legislatures, governing or advisory groups, local communities, etc. As long as the band of variation (the difference between the lower and upper limits) is large, little pressure exists to make the system behave more efficiently, but certainly the mandate of society to all its formal organizations which provide educational and health services is to seek ways to operate as close as possible to this line of optimization (3).

An improvement in system efficiency would be represented on the graph by a curve with a much narrower band of variation, that is, very close to optimization. The position of this paper is that the incorporation of systems theory as a decision-making strategy by mental health could provide a means to achieve such a line.

IV. Using the "Systems Approach"

At least five processes or efforts seem necessary for mental health to use the "systems approach." Each is briefly outlined below. It should be noted that these are not fixed, formal

phenomena but to some degree are involved in all parts of a total mental health organization.

A. *System Definition*—An essential ingredient of any purposeful, formal social organization is a definition of itself, that is, a determination of what the boundaries of the system are, what relationships make up the total system, and what types of subsystems are involved. We too often speak of the "mental health system" or "a part of the system" with only a dim notion of what this "system" might be. Formal organizational relationships, as for example in a hospital, are not those which define the actual social systems functioning within the confines of the hospital grounds. Because they are in the same geographical proximity does not insure that all systems are inter-relationed. They may function quite independently of one another.

B. *Goal Statement*—It has been noted that no formal system can be purposeful without a set of goals, and if a mental health organization is a purposeful system then it should be able to state its goals. Goals may be stated in a variety of levels which would include overall organizational goals, goals of various sub-systems, and even individual goals of the various participants. Goals at each level should be congruent with all higher level goals.

We should consider two popular but erroneous assumptions about mental health goals. First, "we know our goals; they are self evident in our programs." Such a belief confuses activities with goals and leads into a cyclic thinking such that activities are assumed to be "goal directed" therefore increasing the number of current activities will improve the goals. Second, "we all know that our goal is to improve mental health or prevent mental illness." I suggest that we do not know operationally what we mean by mental health or mental illness, not in this most generic form. Do we mean the "sick people" with whom we have professional contact or do we mean something else. This second assumption points up the need for careful definition of all terms as essential to understanding any goal statements we might formulate.

C. *Planning*—Planning has to do with a specific determination of future mental health needs of the population-to-be-served, the available resources such as staff, facilities, equipment, and supplies, and types of goals and accompanying activities which will be needed to meet the future needs. Where possible, there should be a determination of long and short range goals with an appropriate target date for each.

D. *Information (Message) Retrieval and Dissemination*—The heart of a purposeful organization is a network to gather and disseminate messages necessary for optimal decision-making. Information, it should be noted, is *not* a physical phenomenon which is shipped from place to place like coal or steel. Rather information is that which enables a decision-maker to reduce his choice uncertainty or select between alternate possible behaviors. Physical stimuli or messages (that which is commonly called "information") such as numbers, sentences, hand gestures, facial expressions, are but the vehicles or codes which may or may not have information potential depending upon the receiver of the message. Therefore, if we just collect data or maintain records with no concern for the potential decision utility, we have no insurance that we are producing "information".

For any mental health program or set of activities to function as an open morphogenic system, each decision-maker involved must have that information more relevant to his range of decisions. Making relevant information available is analogous to hunting birds with a rifle as an alternative to a shotgun. We have traditionally carried out mental health activities by using a "shotgun" approach which sets up a wide pattern to increase our chances of success. A great many programs are broad in nature and general in scope in hopes that somehow good effects will occur. If in hunting one knows exactly the velocity and direction of the bird (and one is a skilled shot), a well-placed bullet would accomplish the same result as a broad scattered shot-pattern. *In the operation of mental health organizations it is realistic to believe that we could achieve the same results with less resources or much improved results with the same available resources if we had much more information about the total system and its interaction with the environment.*

To maximize its feedback capabilities, a mental health system requires a comprehensive program for the acquisition, dissemination, interpretation, and storage of relevant information. Such information would be (1) external, i.e., be concerned with the environment in which the mental health system operates or more specifically, the potential population to be served, community profiles and needs, available fiscal and social resources to complement any mental health efforts, unique mental health problems, and the community structure or culture which could affect mental health efforts in an area; (2) intrasystem, i.e., be concerned with the internal behavior of the system(s) such as the nature and

activities of personnel, patients, facilities, financial support, and management; and (3) intersystem, i.e., the interaction of the system with its environment as typified by the influences of society on mental health efforts, the impact of mental health programs in meeting the needs of society, and the educational innovative nature of the mental health program.

A community clinic director has unique information needs which are different than even the deputy commissioner assigned to his region. A community clinic director manages a particular type of sub-system and requires detailed information about this sub-system. On the other hand, the deputy commissioner assigned to the region is interested in the general behavior of the sub-system as well as the behavior of many other sub-systems throughout his area of responsibility. He requires information about a larger set of unique systems and their overall behavior.

A comprehensive information network may be likened to a pyramid such that as information flows upward to each level of more general responsibility it is summarized and generalized to the needs of each level. This is in contrast to the type of networks which most often develop in formal organizations which take the shape of inverted pyramids such that information accumulates as it moves upwards with little or no effort to summarize so that each level is exposed to the same information provided for all previous levels.

E. *Program Evaluation*—To make efforts at definition, goal statement, and information dissemination functional, a continuous program of system evaluation must be carried on. This is the "feedback" capability of a mental health system. Feedback includes (1) an information-gathering capability, (2) an ability to analyze information for purposes of decision, and (3) capability to modify and change behavior accordingly. Simply collecting data (or any other messages) is *not* feedback.

Evaluation is the monitor which steers the system back into its appropriate path, that is, determines its ability and potential for reaching the defined goals and makes corrections accordingly. It is dependent upon the sharpness and relevance of definitions and the goal statements which are the basis for its function.

To carry out these five processes, it seems necessary that at least three distinct types of activities should be involved in each process as shown below. As with programs these activities are not necessarily defined by a particular group of people but rather

something which involves the entire system, some elements of the system more than others.

(1) *Theoretical Formulation and Model-Building Activities*—This paper recognizes no distinction between "practicality" and "theory". Rather than being a strict dichotomy, we must consider all our activities as theoretically based. Each of us use a large number of theories in "doing our jobs" which we rarely question since they are so familiar. We assume our notions and concepts to be real, workable, and therefore "practical." A more meaningful way of characterizing theory is on a continuum bounded at one end by unreliable and useless theory and on the other end by reliable and useful theory. This continuum evaluates a theory in terms of its ability to aid us in ordering and predicting our world.

It is the belief of this paper that any social organization which hopes to provide meaningful service to society both now and in the future must be willing to make investment in the development of formal theory relevant to its activities. The formal statement of theory forces one to sharpen the types of relationships which we expect to exist in a system and more importantly to state the assumptions which must underlie such relationships. These formulations which may take the form of models or conceptual schemes can well provide the basis for something we might call the "science of mental health administration".

A similar conclusion was recently drawn by Paul H. Kusuda, head of the Bureau of Research, Wisconsin Department of Health and Social Services, as he said:

> "We must be adroit enough to be perceptive to the dangers of over-simplification attempts by budget and administrative analysts whose job orientations are such as to try to quantify that which may not be quantifiable in our current stage of development in social research. We must understand the needs for that type of evaluation; however, we shall have to be careful to ensure that theoretical formulations are not discarded lightly in response to administrative expediencies." (5)

(2) *Research and Testing Activities*—Continuous research is important to the development and maintenance of a reliable feedback mechanism in the system. Research itself should exist in both formal, structured efforts as well as in informal and unstructured efforts throughout a total system. Simply raising questions about one's activities is a way of initiating research and is healthy

to any formal social organization in order to insure continued relevancy with its goals. Research activities should provide empirical data to be used both in evaluation of theoretical models, evaluation of existing program activities, and guidance for management decision-making.

(3) *Implementation and Application Activities*—The actual implementation of a "systems approach" in mental health is the final test of activities in categories (1) and (2). Implementation and application activities should be continuously involved with theoretical development and research efforts; no clear, static distinctions should exist among them.

The interaction of the five proposed programs and the three areas of activity is shown in Figure 2. The activities shown in the block matrix are but suggested ones and not necessarily the only types of activities which may be carried on. Such a matrix does illustrate the dynamic interplay between the various components. Note the manner in which each activity can be integrated with each process in a most complimentary manner.

FIGURE 2

Matrix Illustrating Utilization Of General Systems In Mental Health

	System Definition	Goal Statement	Prediction—Planning	Message Retrieval and Dissemination	Evaluation—Goal Direction
(1) Theoretical Formulation and Model-Building Activities	Develop conceptual model of mental health systems.	Link theoretical model with operational goals. Simulate to determine possible outcomes.	Develop prediction models of population and community needs and available resources. Simulation of models under a variety of planning strategies.	Develop models for information-gathering.	Develop management models.
(2) Research and Testing Activities	Establish operational definitions of theoretical system models and test accuracy and applicability.	Work with participants to obtain goal statements and make operational. Determination of long and short-range goals with appropriate target dates.	Obtain information about potential mental health needs of population and communities and available resources. (Staff-facilities-supplies)	Determine information needs of each decision-point. Develop information-gathering techniques. Evaluate and sharpen research tools.	Develop and sharpen criteria for evaluation.
(3) Implementation and Application Activities	-Pilot use of conceptual models to determine applicability.	Use of goals to aid system purposefulness.	Use of information provided by models and empirical investigation to determine required goals and related activities to meet future mental health needs.	Gathering information about population and communities served and mental health activities. Summarization and dissemination of information relevant to each decision-point. (Information about what is actually being used with what effect.)	Evaluation of activities in terms of stated goals. Determine if most effective use of resources being made. Evaluation of goals. (Compare use of resources with planned use.)

SUMMARY

This paper has presented a possible strategy which could be utilized by mental health to make its systems more viable. Related programs and activities have been outlined in the most general terms, for the operations which put meat on the bones of such a skeleton will be the result of the interest, background, motivation, and perception of the participants in the system.

For additional reading in the area of general systems theory and cybernetics, attention is called to Buckley (1) and especially his chapters on "Systems", and "Social Control: Deviance, Power and Feedback Processes", and a paper by Harold Halpert, Chief, Systems Research Section, Applied Research Bureau, National Institute of Mental Health (12). Other excellent references include: (4), (6), (7), (8), (9) and (11).

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GROUP ORIENTATION WITH TEEN-AGE VOLUNTEERS

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Current literature is increasingly emphasizing the volunteer's complimentary service role. Balfanz speaks of the "Volunteer Renaissance" which is attracting the "new breed" to whom the altruistic motive of helping others may be less important than the desire for self-development and self-expression.[1] Recruitment efforts are giving priority to youth groups,[2] and stress is upon using their special talents[3] in diversified programs.[4] Active orientations are needed to better equip them to learn from their service experience.[5] A lag, however, exists regarding evolving orientation programs for youth volunteers in mental hospitals.

The standard orientation emphasizes: (a) recognizing community attitudes toward mental illness, (b) relationship between hospital and community for helping volunteers become public relations emissaries, (c) general discussion of the background, nature, variety, and degrees of mental illness and defense mechanisms, (d) preparation for meeting patients' pathological requests, and for the often subtle kinds of manipulation patients will practice to get a volunteer to do things for them, (e) recognition of personal limitations so that the volunteer may grasp what he can do and also what must be left up to professionals, (f) explanation of professional roles and psychiatric treatment process to better help the volunteers to conceptualize their service role.[6] Such an orientation does not give special emphasis to arming volunteers to readily recognize and work with the patients' healthy residuals.

This paper describes a group consultation experience which stressed positive mental health principles, thereby maximizing

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This program report was prepared within the framework of activities supported by the V. A. Program Evaluation Staff (PES). Special thanks are expressed to the participating volunteers and to Mrs. Margaret Canupp, PES secretary.

young volunteers' search for self-growth. During the summer of 1967, eight weekly one-hour sessions were held, and attendance was entirely voluntary. Each orientation was structured into three parts: (a) an introductory phase where formal presentation came from chapters 2 and 3 of Marie Yahoda's, *Current Concepts of Positive Mental Health*, [7] (b) an involvement period with role-playing tying in presented points to their daily lives, and (c) a wrap-up discussion to apply these concepts in their work with patients. This vivid approach was intended to facilitate the group process, with its ". . . initial warming-up phase, a problem-focused phase, as well as an ending phase."[8]

Description of the Volunteers

Each summer the Red Cross Director in a neighboring city of 70,000 selects "new breed" volunteers from seven high schools. Seventeen youth from this group—one boy and sixteen girls—who were assigned to work at the Salisbury V. A. Hospital on a particular day of the week were asked to participate in this group orientation program. To objectively evaluate experimentals' change, the program included a matched control group of volunteers who were selected by the same method, yet who chose to serve in the hospital on a different day of the week. There was no difference in the assignments between groups as both served mainly in Nursing and Physical Medicine and Rehabilitation Services. Their roles were generally to stimulate chronic patients into more awareness of themselves, others, and their surroundings through discussions of common sense topics of mutual interest and by active participation with patients in games, assignments, and outings.

To gain an objective evaluation of the participants' attitudes toward mental illness, Cohen and Struening's *Opinions about Mental Illness* OMI)[9] rating scale was administered the week before and the week after the sessions. The initial test results cast both groups in a very favorable light since they were highest on the positive cluster of benevolence and mental health ideology. The negative cluster consists of authoritarianism and social restrictiveness. Another scale, interpersonal etiology, is negligibly related to the other scales.[10] Benevolence is defined as: pro mental patient emphasizing the virtues of charity, self-improvement, home life, and positive thinking; and it rejects the position that patients are dehumanized failures in life. The definition of mental

health ideology is: a positive view of mental patients and an optimistic attitude toward their recovery; differences between mentally ill and normal people are not sharply emphasized, and it reflects a generally positive, optimistic, and differentiated conception of mental illness which is based *on the main tenets* of mental health professionals.[11]

Thirteen attended six or more of the eight sessions (an excellent record considering absences due to family vacations; for example, only six were present over the Fourth of July holiday), and ten came for retesting. Ten controls also came for retesting. Statistically significant changes were not expected since there were so few sessions in which to work toward attitude changes, along with the indirect, slow nature of the group consultation process.[12] Trends worthy of mention on the retest were: benevolence was slightly lower and mental health ideology was somewhat higher (as on the pretest, each member rated highest on benevolence). There was a dramatic change in mental health ideology in that on the post-test, 9 experimentals rated second highest on this factor as compared with 5 on the pretest; none of the controls increased on this factor. This points to growth as a result of the orientation in positive principles of mental health.

Highlights of the Sessions

The formal presentation in Session I interpreted the fittingness of abnormal symptoms in extreme circumstances with two volunteers role-playing their reactions to learning of a close friend's death in an automobile accident. One responded in a stunned, glassy-eyed fashion, characterized by feelings of unreality. The other showed a great sense of loss accompanied by sadness. Group discussion brought out that a volunteer's aunt had temporarily "imagined things" after her husband's death. Several others recalled similar instances. Possible reactions suggested by those who had not role-played were anger, resentment, wild excitement, extreme "nervousness", and fear. The freeing effect of self-expression in acute times was pointed out; also, that dreams were a way for the mind to deal with inner tensions which could not be "thought out." Patients' "talking to themselves" concerned them; yet they were just as curious about those who acted "normally." These young volunteers became involved in the very beginning session, agreeing with Berlin's experience with young

consultees, who, he relates, actively ask questions and make requests and sometimes demands.[13]

The concept of "normality" was questioned in the second meeting. Role-playing pictured difficulties in "being oneself" after running out of gasoline on a long, deserted road in the middle of the night. The discussion brought out difficult problems already encountered in their work with patients; i.e., how does a volunteer react to patients who hoard trash, talk vulgarly, imagine themselves to be great leaders, never speak, or curse other patients? Regarding disagreements between patients, they were encouraged to allow the patients time to work out their differences before responding or calling in staff. In situations where patients disagreed with volunteers, they were advised that an exchange of viewpoints could be helpful if the patient's agitation level did not unduly rise. The patients' short attention spans, low tension thresholds, and lack of perseverance in assignments were noted. It was suggested that they gently, yet firmly, encourage the patients to participate in the various activities. Patients who dwelled on thoughts of alienation from their family members and those who offered gifts of candy to the volunteers were also mentioned during this session. The group came to feel that the patients' "real attitudes" should be gauged to help guide their responses. The value of remaining flexible and willing to experiment was stressed.

The theme of the following session pointed out that contentment is not always an appropriate reaction. In a role-playing situation, two volunteers tried to remain contented after learning of their dismissal from the school's most desirable social club. This topic was difficult for them because of the adolescent's strong need to belong. They tried to be pleasant but the "forced smiles" told the tale. In a discussion which followed, one volunteer mentioned that anger and hurt were her main emotions to actually being dismissed from the club. Several outcomes of bucking the group were mentioned such as losing popularity and friends and the frustration of being forced to be a "loner." A clear conscience and the strengthening effect of "standing for something" were mentioned as rewards. Contentment had little meaning in their dealings with patients.

Objective introspection was emphasized in the fourth session with role-playing leading the volunteers to look closely at the emotions they experienced on their first dates. This situation was overly personal to the teenagers, and several times they threw up

their hands and smiled in embarrassment. The discussion showed the volunteers divided in their recollections of their first dates—many had been highly anxious, some had not, and several could not remember. Meeting their first patient, however, had caused all to have uneasy feelings; words came hard. The usual attitudes of friendliness, interest, and smiles brought little response! Never had they looked so "long and hard" at their personality patterns.

In Session 5, emotional growth and self-actualization were the topics. Role-playing centered upon the investment in living which led to the participants' becoming volunteers. Their reasons revolved around learning more about nursing, peer recognition, and spending part of the summer in a valuable way. In discussion, the volunteers' voiced definitions of growth were: developing oneself for the future, facing reality, assuming responsibility, learning to live with one's problems, and working toward maturity and happiness. Accepting assignment responsibility with patients was a recognizable way they had put growth concepts into action. They had discovered that the patients' odd actions and thoughts and their extreme emotions such as anger or humor, rather than engulfing them, tended to emphasize their own healthier ways of thinking. By this session they had progressed to the point that it was not embarrassing for them to ask why patients occasionally talk vulgarly or make sexually-tinged remarks. Generally, patients' masculine-identification problems were noted such as extreme bids for attention to cover up passivity. For specific information, however, they were referred to the supervisors in their areas of work. After struggling with the growth topic and their work problems, they came to realize that to grow tends to be a hard and painful process.

Session 6 dealt with the integrated personality. Two members role-played their ambitions—where they would be ten years hence. Long-range goals and expected tensions and frustrations were pictured. Both expressed interests in nursing (one planned to get a certificate and the other an M.S. degree). They explained how the current volunteer experience figured into their plans. To show the discipline involved, one related that this fall she was planning to sacrifice extracurricular activities to serve as a candy-striper in the general hospital of her city. The group felt that the qualities they most admired in older leaders and would like to emulate were: strength, firmness, an understanding and warm manner, and a knowledge of and liking for their work. When asked if they had seen signs of goal-related approaches taken by patients, they

remembered that several had systematically worked toward privilege status, passes, and discharges. Their lack of fear and anxiety had helped deviant patients act in a more socially acceptable manner.

Session 7 introduced the concept of autonomy, revealing that an individualistic person seeks development, regardless of the obstacles, and not by "quicky or questionable" methods. In a role-playing situation, a member defended why she had voted against the majority in a club project. Independence was a foreign theme for these adolescents; they smiled and constantly compromised. In the discussion which followed they held tenaciously to "groupness"—it was as if they were fearful of losing their "individuality" by pursuing such themes. Elms' review notes the great resistance which is involved in changing attitudes through role-playing when the person's verbalizations are not in line with private attitudes.[14] They were complimented for their growth in serving patients. The question then arose regarding whether it was easier to stand for something with patients or with fellow volunteers. Ironically, a clear-cut difference of opinion developed! Those who said it was easier to stand for something with patients presented these arguments: (a) It doesn't "hurt" as much to take stands with patients because there is not as much emotional involvement. (b) Patients do not question your authority as much as volunteers. (c) The requirements of working with patients are spelled out, whereas with volunteers one has to "feel his way." (d) Patients' reactions are slower and not as complex. The arguments from the other side related to the lack of difference in taking stands: (a) Standing for something is to tied up in principles that it doesn't matter whether one is dealing with patients of staff. (b) Age and interest differences give unique problems to both groups. (c) Differing with anyone is difficult because of risk. (d) There is a conflict between empathy versus sympathy between the groups.

The theme of the eighth session related to environmental mastery, emphasizing that mentally healthy people, even in difficult situations, pursue living without severe need distortion and have the capacity for social sensitivity. For the role-playing situation, three family members—two sisters and the mother—sought the family car at the same time. One sister needed the car to go to the library to complete an important school assignment; the other wished to visit a girlfriend; the mother needed to get several items from the grocery store. It was clear that the school assignment was the most important, yet each was active in pushing

their purpose in give-and-take striving before reluctantly, yet graciously, giving in. No one "lost face" and "right prevailed." The later discussion centered upon the rights as well as responsibilities of family members. They could see the strengthening effect of the regular cycle of "ups and downs" of family living. They felt, too, that the interaction with patients had a strengthening effect upon them. Patients now were not "just patients," but each was recognized as having an individual personality with strengths which needed to be found productive service.

The most outstanding indication of their environmental mastery was revealed as they criticized the leaders and made suggestions for improvements. The formal presentation was rated "dull" (the leaders do not contest this evaluation but knew of no other way in which to make the positive mental health "plants"), and the volunteers doubted that role-playing was needed. They would have liked more reference to their outside lives and would have had a teenage volunteer present only simple points in a "gab session." They were, however, enthusiastic about the sessions as a whole.

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DISCUSSION ON COMMUNITY MENTAL HEALTH CENTERS PROGRAM*

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I appreciate having the opportunity to talk with you this afternoon to tell you something about the Community Mental Health Centers Program, but more specifically to talk to you about an issue which is of considerable concern to those of us at NIMH and one which I think is of considerable interest to those of you who are here.

Specifically, I am talking about the relationship between the private practice of psychiatry and the development of Community Mental Health Programs, and even more specifically I have in mind the matter of the relationship between private practice and our professional societies, particularly the district branches on the one hand and the development of community mental health centers on the other. Just to begin with, briefly, I would like to give you a little information on where we stand with the Community Mental Health Centers Program and something about what has happened in the 3 or 4 years the program has been in operation. Already there are about 300 Community Mental Health Centers that have been funded by NIMH under the Community Mental Health Centers Program and it is anticipated that several hundred more will be funded in course of the next several years. There are now about 100 of them in operation and we anticipate another 100 by the end of the calendar year 1968 and an ever growing number of operational centers in several years to come.

One of the more important jobs of the Community Mental Health Center, so far as we are concerned, is that it provides an opportunity to bring together both the public and the private sectors of psychiatric practice. I don't think that I have to belabor the point with this group that for a number of years, for many years in fact, there have been two separate systems of psychiatric practice, the private, including the work of private practitioners,

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* Presented at the meeting of the District Branches of the ADA.

voluntary general hospital psychiatric units and private psychiatric hospitals, and on the other hand there has been the public system with public state and county mental hospitals and public clinics. One of the ideas behind the Community Mental Health Center concept was an effort to merge these two systems into some kind of cohesive unit, call it what you will, a whole package of mental health services. It is obvious that given the limitations on our psychiatric manpower and given the needs of the mentally ill in this country, that we have to approach the problem quite directly of bringing about some kind of unity in order to develop a reasonable and most effective utilization of the services that we have to offer.

One of the things that we have seen developing in the several years of the Community Mental Health Center is the fact that it has been successful in bringing together both private and public aspects of psychiatric practice. The success in this kind of unification, I think, can be seen in a couple of ways. One is in terms of the finanical structure of the typical community mental health center. At the moment the average center in its first year of operation is spending approximately a million dollars and of this, some 35% is coming from a Federal grant, another 40% is coming from the public treasuries of state and local government, and the remaining 25% is derived from private sources, including both individual patient's fees and third-party insurance payments. So financially the Community Mental Health Center has its roots in both the public and the private sectors. The roots going into both sectors can be seen to go not only into the financial structure but also the organizational structure of the Center. Whereas, most of them are composed of two or more combined participating agencies, 75% of them include a general hospital and the vast majority of these general hospitals are voluntary institutions. So the evidence suggests that the centers have been quite successful in involving the private sector of psychiatry, but the evidence also suggests that this success has been in terms of financial structure and organizational structure. What is still missing in a considerable degree is any real involvement of the private psychiatrist and what I think is equally significant is that there is missing any real involvement on the part of the APA district branches in the planning and developing of Community Mental Health Centers.

Community Mental Health Centers, quite literally, are changing the character of mental health services throughout the nation, but the privare practitioners and the district branches have been really sitting on the side lines watching the changes take place.

The leadership and the planning and developing of centers have been taken on by a variety of other groups—the state mental health authorities, local public health agencies, hospital associations, regional hospital planning groups, even local mental health associations have been the active ones in developing centers. All have been involved in making decisions which directly influence the district branches and the members of the district branches, but the District Branches and the district branch membership have not really been involved in this kind of activity. We know that private practitioners and local societies can be involved in community mental health centers; we know of several examples where the center provides services relying almost exclusively on the clinical services of private practitioners; we know of one center which is essentially a private practice model which operates through the provisions of services essentially all of which are provided by private practitioners on a fee-for-service basis.

Dr. Ozarin will be describing some of the model centers to you. But in terms of actually organizing centers and in terms of getting centers established, for the most part the private practitioners and the district branches have not been in the picture. The private practitioners and the district branches should be working at state and local levels with the people who are involved in mental health planning and the development of community programs. I think that the district branches should also be involved in the creation of new mechanisms for the involvement of private practitioners in the operation of centers.

Officially, I am talking today as a representative of NIMH but I guess I am also talking about money which is our preoccupation since Congress is about to reduce the amount we have available. We know that one of the problems that has plagued us thus far in terms of involvement of the district branches with us in developing community programs has been a matter of communications or information. Many people in the district branches simply do not know enough about Community Mental Health Centers and, unfortunately, some of the information that is available and is around is really misinformation.

On Friday, Dr. Brosin and I had the opportunity to meet with the Policy Committee of the Assembly and at that time we discussed what I think is an excellent example of the kind of lack of information of misinformation. Specifically, we were talking about the Community Mental Health Center catchment area requirement. I think you are all probably aware that the Federal

regulations say that a community Mental Health Center must serve a catchment area and also says that this area must be on the order of 75,000 to 200,000 people in size.

What is not known though is that although a community mental health center must serve a catchment area, it is not true that a community mental health center must serve only that catchment area. I think that, unfortunately, many practicing psychiatrists do not know this and that many center directors and administrators of community mental health centers do not realize this, or do not want to realize this. But I think that it is a lot more important from the vantage point of the private practitioner, and from the vantage point of the district branch, to be aware of the possibility of a center serving a much broader population since this opportunity really provides the wherewithal for private practitioners and members of district branches generally to take part in a community mental health center since they need not focus their attention entirely upon a single restricted catchment area.

Now obviously, as much as bureaucrats—and having identified myself with the bureaucratic machinery as much as we like to talk about regulations, my role this afternoon is not to try to explain the Federal regulations to you. What I have been trying to do is to point out to you what I feel is a tremendous need for district branch involvement in community mental health centers programs. I feel that this kind of involvement is a major gap in our current operation. I have been trying also to emphasize what I think are some of the opportunities that the centers program provides, for example, through the fact that the center need not focus all of its attention, 100%, of a catchment area. I have tried also to identify the information gap which, as I say, came out of the discussion on Friday with the Policy Committee. As one of the major problems that has confronted both the district branches and the NIMH in regard to bringing the district branches to have more involvement with the centers program.

On Friday, also, we had a chance to talk some about the possible solutions to the information problem and as a general possibility, we considered an effort to get information about the program directly into the hands of the district branch membership. All too often, what has happened is that some of the district branches have had members serving on the state level advisory committee and what the assumption I think has been is that a member in his role as an advisory committee member at the state level will then bring back the facts and the information to the district branch. My own feeling is that this doesn't always work.

It may work in some cases but usually I think that if the district branch is to have the information available to it, they have to get it directly. I think that a district branch member who serves on a state or local level planning group or council is in a much better position to take an active role on that council, or in the planning position, if he gets his information from the group which he represents, namely, the district branch and the psychiatric profession. Now, certainly there are already a number of existing channels for distributing information to the district branches and we would hope to be able to make use of them to get information, accurate information, about a centers program out to you.

But there is one other piece to this besides the information flow. It is the matter of involvement of the district branches in some kind of a continuing dialogue, not only with NIMH with our responsibility for the program on the national level, but a dialogue between the district branches and the other groups in the states and communities that you represent concerning the development of community mental health centers in these areas. The hospitals are interested because they are interested in expanding programs, often because they are interested in construction possibilities. Clinics are interested, so are mental health association and public agencies. What I am trying to urge you today is to develop this same kind of interest in your district branches and to take part in the planning and development and the creation of the community mental health centers that are being established throughout the country. Thank you.

DISCUSSION ON COMMUNITY MENTAL HEALTH CENTERS PROGRAM

Dr. Lucy Ozarin °
Development Officer
National Institute of Mental Health

I will just pick up a few things that Alan has talked about. Some of you may remember that four years ago Bert Brown and I had the opportunity of addressing the assembly when you met in Washington, D.C. The centers program was very new then and we were a little starry eyed. Well, we have had four years of experience in facing reality and a few of our ideas have been modified, but basicly I think the direction of the program still stands. In fact, much of the entire direction in the Federal part of the health programs has gone in this direction. Planning and bringing the program down to the grass roots, the regional medical programs Title XVIII and Title XIX are not too far different in the way services are to be delivered than the central program. We are not unaware that there will have to be other changes as time and situations change, so we are hoping to keep current. This is where we need feedback about the situations which need to be changed from where we sit because of conditions locally.

Alan has talked at some length about the role of the district branches in the planning and involvement with state agencies and other planning groups. It is a real role and I would like to say something about the role of the private practitioners. We are particularly focusing on private practitioners here because we have established communications with other groups, the state mental health authorities and the commissioners. We have ways of reaching and getting feedbacks from them, but we haven't really had a good channel to the private practitioners. This was one reason we particularly hoped to have an opportunity to talk with you.

The centers can be divided into a couple of groups. Basically, there are those centers which have full-time staffs and those centers which do not have full-time psychiatrists. The full-time staffs are usually found in the public sector. You find them in the public

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° Dr. Lucy Ozarin, Program Development Officer, NIMH.

mental hospitals and we have a group of state hospitals that have gone the central route which have set aside a part of their buildings and serve the immediate counties like in Delaware, in Arkansas and Rochester, Minn. Their state hospitals have gone that route. We have seen this happen with city hospitals like Denver General which has become a mental health center serving a couple of catchment areas. Again this is public. Close to a third of the medical schools in this country have applied for mental health center funds and are serving catchment areas which we feel is quite a development for they are still involved in training. There are other groups—the general hospitals, particularly the voluntary general hospitals either in the smaller cities, the city, country areas from 200,000 up to 400,000-500,000 and in the suburbs, and even in the inner city. We have some concern about the voluntary hospitals that have applied and in a good manu cases have been granted center funds, and it is with reason because they have part-time psychiatric coverage, usually. Sometimes they may have a full-time psychiatrist, but we have had one experience where the medical staff of the hospitals said they wouldn't have a full-time psychiatrist because the rest of the medical staff wasn't full time.

I think the program is a multi-service program. It is a complex program and it takes a lot of coordination not only within the hospitals but within the community because, as you well know, there are many problems in the community where you have people who have emotional problems in living and there are certain areas that have to do with the public health aspects of mental health, or the public health aspects of psychiatry. In these areas private practice doesn't seem to get involved. I am a little worried about it. We've got to find some way to solve the problem.

Another problem that we have seen is that some of us have not had experience with some of the newer developments like partial hospitalization. Occasionally, you will find a private psychiatric hospital, or a general hospital, that has well-developed day care programs. I think Mt. Sinai has had one for about five years, and practically every staff doctor is also in private practice. Few doctors have had experience with day care in their private practice, and yet this can be useful. With the rising cost of 24-hour care, it becomes important to know about this. So there is need for continuing knowledge in this aspect of care.

Another area which is most important is the one concerned with the payment for services received by the Blue Cross Plan

and by some of the insurance plans. At the present time these plans do not reimburse the hospital for partial hospitalization programs. This is an area where the District Branches could work with the local Blue Cross and other insurance carriers to have the partial hospitalization programs covered in their policies, otherwise reimbursement will only be granted for 24-hour hospitalization and thus the partial hospitalization plans may not be developed.

Our office would appreciate hearing from District Branches on the kinds of problems arising in your part of the country in respect to the Community Mental Health Centers. If we can establish a two way communication system with you, we will be able to function more efficiently.

BOOK REVIEWS

Being Mentally Ill: A Sociological Theory,

by Thomas J. Scheff, 210 pp., $5.75,
Aldine Publishing Co., Chicago, 1966.

The kinds of deviant behavior called mental illness are described by Scheff via the concepts of social process. In his view chronic mental illness is in part a social role and societal reaction is usually the most important determinant of entry into that role. Ordinarily, the term deviant means undesirable; but in this book, deviant is defined as an evaluation made by society in terms of accepted norms. Therefore, deviance is a consequence of the responses of others to a person's acts. Scheff feels that the usual dynamic psychiatric formulation fails to incorporate social process. His purpose is not to reject psychiatric formulations totally, but rather to develop a model which will complement the individual system model.

Three problems are cited as crucial for a sociological theory of mental disorder:

1. What are the conditions in a culture under which diverse kinds of rule-breaking become stable and uniform?
2. To what extent are symptoms of mental illness the result of conforming behavior?
3. Is there a general set of contingencies which lead to the definition of deviant behavior as a manifestation of mental illness?

The term mental illness suggests a process which occurs within the individual. Most rule-breaking or norm violations do not cause one to be labeled as mentally ill, but rather as ill-mannered, sinful, or criminal. The usual working hypothesis of physicians when confronted with a sign or sympton, however, is that of a progressive disorder which will get worse without medical intervention. Nevertheless, the great majority of people with psychiatric symptoms go untreated and thereby unlabeled as mentally ill.

Scheff points out that the stereotyped image of mental disorder is learned in childhood and reaffirmed subsequently in ordinary social interaction. Newspapers commonly mention when rapists or murderers are former mental patients. They rarely if ever

state, "Mrs. X, former mental patient, was elected president of the Home and Garden Society." Such differential reporting tends to confirm the public image of insanity. Glass, in relation to military psychiatry, discussed the critical nature of the labeling process, i. e., labeling, removal, and hospitalization and the way in which it increases residual disability. Labeled deviants may be rewarded for playing the stereotyped deviant role. Psychiatrists may encourage patients to recognize and accept their illness and achieve "insight." Nevertheless, labeled deviants are punished when they attempt the return to conventional roles for rejection of the mentally ill is largely stigmatization, rather than evaluation of their actual behavior. A person having been in a mental hospital or seeing a psychiatrist may be labeled and rejected; whereas a person seeing a clergyman is viewed as participating in a socially acceptable process. The same applies to a psychotic individual not seeking help as contrasted to a less sick person seeking psychiatric treatment. The more the person enters the role of the mentally ill, the more he is so defined by others and encouraged to maintain the role.

Physicians frequently encounter uncertainty and have developed norms for handling this so as to avoid paralyzing hesitation. Judging a sick person well is to be avoided more than judging a well person sick. The bias is toward treatment. The physician may search for illness for an indefinitely long time, causing inconvenience for the patient, but no great harm. Such reasoning is dubious in terms of psychiatric patients, i. e., the investigation itself may label the patient as deviant. Mental illness may be more usefully considered as a social status than as a disease since the symptoms are vaguely defined and widely distributed. There tends to be a strong presumption of illness by psychiatrists and the courts. Scheff believes that mental health officials handle uncertainty by presuming illness and that this presumption reenforces the social role of being mentally ill.

Five doubtful assumptions about mental illness are discussed:

1) The condition of the mentally ill patient deteriorates rapidly without psychiatric assistance.

2) Effective psychiatric treatment exists for most types of mental illness.

3) There are no risks in involuntary psychiatric treatment. It either helps or is neutral in effect. It is not harmful.

4) Exposing the prospective mental patient to questioning, cross-examination, and screening is harmful in that he is subjected to the unnecessary stigma of a trial-like procedure.

5) There is an element of danger to self or others in most mental illness; therefore, it is better to risk unnecessary hospitalization than the harm the patient might do.

In *Being Mentally Ill*, Scheff outlines an approach to studying a system involving the patient, other persons reacting to him, and official agencies of control and treatment in society. It is an excellent example of the "deviant" thinking necessary to maintain psychiatric theory as an open system. The reviewer recommends this book with enthusiasm to any mental health professional with an open mind.

R. L. Rollins, Jr., M. D.

NEWS NOTES

AMERICAN PSYCHIATRIC ASSOCIATION

The American Psychiatric Association is about to undertake a project to study current adequacy of psychiatric patient records under a contract with the Public Health Service and sponsored by the National Institute of Mental Health. Purpose is to highlight current problems in record keeping and present recommendations for further study. Mrs. Ann Ball Gottschalk, Coordinator of Medical Records for the North Carolina State Department of Mental Health has been named one of ten people who are to be the study group working with the project.

Notice to Contributors

Manuscripts and editorial comments should be addressed to the Editor-in-Chief, N. C. Department of Mental Health, P. O. Box 9494, Raleigh, N. C. 27603.

Contributors need not be psychiatrists, neurologists or M.D.'s but should be involved in some aspects of program, whether clinical, educational, or research, pertinent to mental health or mental illness.

Manuscripts offered for publication should be submitted in the original, typed on bond paper and double spaced with 70 characters per line. Footnotes, bibliographical references, quotations, etc., should also be double spaced and the use of footnotes minimized.

References to books and journals should be numbered consecutively in a bibliography at the end in the order in which they appear in the manuscript. References should be limited to those used by the author in the preparation of the article and kept to a minimum.

The author's privilege of correcting galley proofs may apply only to printer's errors.

Tabular material, drawings and charts should be submitted on separate sheets, clearly marked as to where they are to appear in the text.

Vol. III, No. 4 1969

NORTH CAROLINA

JOURNAL OF MENTAL HEALTH

NORTH CAROLINA JOURNAL OF MENTAL HEALTH

Published by
The State Department of Mental Health
in conjunction with the
N. C. Neuropsychiatric Association

NORTH CAROLINA JOURNAL OF
MENTAL HEALTH

Volume 3 Number 4

1969

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NORTH CAROLINA JOURNAL OF MENTAL HEALTH
is published quarterly, Spring, Summer, Fall and Winter.

It is a scientific journal directed to the professional disciplines engaged in care, treatment, and rehabilitation of mentally ill and retarded patients as well as to those engaged in professional research and preventive work in the field.

This journal is intended to be inclusive rather than exclusive and is not meant to be regarded as simply a house organ of the North Carolina State Department of Mental Health.

It is hoped that the journal will reflect the broad-based philosophy of psychiatry current and will draw on areas reflecting the total spectrum of psychiatric and neurologic thought, program and research.

Subscription may be obtained by writing the Editorial Offices, North Carolina Department of Mental Health, P. O. Box 9494, Raleigh, North Carolina 27603.

(Notice to contributors—see inner back cover)

EDITORIAL

The Dumping Syndrome

Physician readers are familiar with the dumping syndrome. Others will have to look up a medical dictionary because this editorial is about another form of dumping syndrome—psychiatric, not gastroenterological.

It seems to me that psychiatrists and the mental health movement are in danger of losing sight of the patient in their search for better results from purely administrative points of view. If a hospital is to boast of its rapid turnover or its reduction of total census, this is fine, provided no patient is "dumped," in consequence. If a mental health center is concentrating on school mental health, this, too, is excellent so long as adult patients are not just ignored or dumped elsewhere. Likewise, the privately practicing psychiatrist who accepts only "interesting" or "important" patients may be guilty of the dumping syndrome. Dumping, you see, is the art of getting rid of someone as a matter of expediency.

Don't get me wrong! I am not against planned referral, or the proper free flow of patients between components of a mental health program. But I think we are all guilty sometime of perpetrating the dumping syndrome. Think, now! Can't you recall several recent instances in which patients were dumped upon you or your organization without good

reason and with inadequate communication? Don't we all know other guys who abdicate their responsibility whenever possible and dump the patient? We, in our turn, make planned referrals for treatment elsewhere!

But maybe the patient **feels** he is being dumped—shifted from one professional or agency to another without good explanation or reason. If so, we are guilty of failure to do our job properly. Are we sure that he really will do better elsewhere than if we continue to do the best we can?

With the psychiatric dumping syndrome, prevention is much easier, and preferable, to cure. It is not an incurable condition. It arises within us and is never consciously sought by our patients. It is true, though, that some masochistic individuals have the knack of stimulating dumping maneuvers on the part of mental health professionals.

So, my plea is for self-scrutiny. Each time we are considering a patient, or family, or other mental health problem, let's ask ourselves: "Is my decision a realistic and correct one, or could I, too, be contributing to the psychiatric dumping syndrome?"

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OCCUPATIONAL THERAPY IN A CONVALESCENT HOUSE

The Use of Group Approach in the Treatment of Long Term Patients

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Located within the hospital is a small unit, the Convalescent House, set up to receive patients referred from the treatment units who are psychiatrically and medically ready to leave the hospital but are socially unprepared. In the past such patients who left the hospital often had to return because of their inability to fit into society. The purpose of the Convalescent House is to better prepare these patients so that the transition from hospital to community is made with greater ease and more success. Under the direction of Mrs. Quinn Murray, ACSW, the house opened in September 1964 with 24 female patients. In August 1965, a male wing was opened with 20 men; it now has a capacity of 30 women and 24 men.

In addition to the director the original team included two social workers, one attendant and one secretary, all on a full-time basis; a consulting psychiatrist, and representatives from Occupational Therapy, Industrial Therapy, and Vocational Rehabilitation on a part-time basis. Gradually more attendants and social workers have been added to provide better coverage and increase the scope of the program. All members of the team are encouraged and expected to participate in the planning and operation of the overall program, from general policy formulation to specific planning for an individual resident. Several avenues of communications, both formal and informal, are constantly open to everyone involved in the program, making possible the coordination of the various phases of the total program and the prompt exchange of pertinent information among team members. This close communication tends to prevent the development of many major problems, promotes the feeling of real team effort, and accounts for much of the success this program has achieved.

The occupational therapy program for the Convalescent House began for the female residents in December 1964; for the male residents in September 1965. From those dates through March of 1967, about 85% of the House residents have been in the occupational therapy program, and an average length of time they have been involved is three to five months. They have had a wide range of diagnoses and the age ranges and lengths of continuous hospitalizations have varied extensively.

When this program was set up, there was a dearth of source material available, therefore, much of what has been attempted has been on a "trial and error" basis. The therapist has attempted to establish a program which provides opportunities to learn and practice everyday living skills and emphasizes these basic principles:

1. Introducing small changes in the resident's way of thinking and behaving in preparation for the greater changes involved in leaving the hospital.
2. Consistently keeping reality factors in mind and reinforcing these with the residents.
3. Emphasizing their being a part of a group, but that each one is also an individual.
4. Creating an awareness of leisure time and hopefully creating an interest in learning or relearning something which might be used as a hobby.

At first glance the above in no way seemed to be unique. In fact, they might seem so commonplace as to be unimportant. They involve everyday actions which "normal" people take with at least some degree of success. However, to these people who have retreated to individually isolated worlds of institutional living, these ideas present quite a challenge.

One of the most difficult obstacles is the resident's tremendous resistance to change. The actual physical move from their previous hospital "home" to the Convalescent House seems to lay the groundwork for many changes; one immediate difference is that the individual is no longer referred to as a "patient", but rather as a "resident". This beginning is followed up in occupational therapy by two types of changes. First are those changes inherent to the program itself:

1. Change of therapist—a new personality for the resident to adjust to.
2. Change to a small group—the resident cannot lose himself in the crowd.

3. Change in schedule—the resident is responsible for remembering what and when to attend and for coming on his own.
4. In some cases simply attending occupational therapy is a change.

Second are those changes initiated by the therapist:

1. In most cases, a change of activities. Even a resident who has stubbornly continued the same repetitious activity for several years is less reluctant to attempt the next change presented him once he has done a new activity with moderate degree of success.
2. Insisting that the resident make some decisions for himself, limited at first, but becoming less limited as he is able to handle them. One lady who sat for two days begging that she be told what to do, voiced what many of the residents probably have felt: "I've been told what to do for so long, I don't know how to decide myself."

One of the greatest changes for many of the residents is realistically thinking about leaving the hospital for good. In order to accept this cold reality, they must learn to face smaller bits of reality in their day to day activities. Such matters as behavior, dress, and work performance are discussed much more candidly with them than they usually are with the general hospital population. "Crazy" talk and behavior are pointed out as being unacceptable on the outside, and discussions about what *is* acceptable are encouraged. In fact, discussions about any phase of everyday living are encouraged.

Regardless of whether group or individual activities are used, the resident is a part of a group while in occupational therapy and in any "normal" situation will always be a part of some group. This simple fact is very difficult to accept for many residents whose motto seems to be "I won't bother you and you had better not bother me!" They find numerous ways of attempting to avoid it—from sitting with the group and ignoring everyone in it to physically moving away and sitting with their backs to the group. In working with these groups, it frequently has been necessary for the therapist to remind individuals that they are a part of the group and are expected to participate in group discussions and activities. These activities provide a very convenient and concrete basis for discussions within the group. The therapist can point out what is happening in the group and help the residents get a better idea of their roles and feel more comfortable in working with others without going into

the dynamics involved. A resident's statement made aside to the therapist at the end of a session: "I would have suggested mashed potatoes, but I was afraid somebody might not like them" (when the group was planning a meal) gives some indication of the tremendous amount of insecurity felt in attempting to communicate. Such statements are not unusual and they graphically emphasize how very much work is necessary in this area if these people are to be able to function adequately outside the hospital.

With so much emphasis on "group", it is also necessary to make the resident aware that he is still a person whose individuality is to be respected. Ideas such as the following have to be repeatedly verbalized and reinforced by the therapist: (1) It is all right to voice disagreement with the group so long as it is done in a civilized manner. (2) It is all right to tell someone that you do not like what he did or said. (3) It is all right to say you want to try an activity different from what everyone else is doing.

The resident has to see himself as an individual before the fourth objective of creating an awareness of leisure time and stimulating ideas for its use can be met. When members of these groups have been asked, "How will you spend your free time after you leave the hospital?", the most frequent answers have been, "just sitting around", "sleeping", a shrug of the shoulders, or a blank look. A very few residents have had hobby interests for years and need only to be provided with materials to continue their chosen activities. However, these are the exceptions rather than the rule. Most of them either lost such interests long ago or never had them at all. Not infrequently, residents who return to the community after extended hospitalization complain of boredom, restlessness, and increasing anxiety. It seems a reasonable conclusion, if not a statistically proven fact, that an activity one really enjoys might help alleviate these symptoms. Such an activity might also provide a means of becoming acquainted with others having similar interests in the community to which the resident returns.

In making the resident aware of these facts through discussions within the group, it is necessary to point out a few reality factors for the individual to consider: (1) How much money will he have to spend for supplies? (2) How and where can he get the supplies needed? (3) Will this be a practical activity in the

setting to which he is going? (4) What community facilities might be available for this activity?

While in occupational therapy, residents have the opportunity of relearning or acquiring skills in almost any craft or sewing-related activity. The women have had a wider choice than the men, and the mechanically inclined men have been particularly short-changed. This is not an oversight, but rather the inability to provide appropriate activities for them. With these individual interest activities, residents are expected to make their own choices, although in some cases their choices have been somewhat guided by the therapist in order to prevent an individual from retreating into his old patterns.

In order to achieve the goals of the program, a number of group activities have been used. Some of these have been initiated by the therapist, but inasmuch as possible they are outgrowths of ideas brought up by the group. When this program was first started, it was felt that all the activities should be group inspired with the therapist as a passive leader; however, it soon became obvious that the therapist would have to be a more active leader— the degree varying from time to time, depending on the composition of the group. When any member of the group has a reasonably feasible idea for a project, the therapist promotes a discussion; if everyone doesn't contribute voluntarily each individual is called on for his opinion. After this discussion a vote is taken and the majority rules. Then there is a discussion on planning how to do the project. This process can become tedious because of the residents' reluctance to make decisions, but it has proven to be the most effective means of getting the greatest amount of participation.

Upon completion of the project, there is a more informal discussion about how it progressed. This is important regardless of how poorly or how well the project has been done. Group activities which produce friction within the group or unsatisfactory finished products can become valuable learning experiences, but only if they are discussed in an honest, matter—of—fact manner so that the residents recognize what went wrong, some of the possible reasons, and what might be done to prevent a reoccurrence. These discussions create an uncomfortable situation and frequently the group members attempt to avoid it by denying that anything was wrong, or insisting that if something did go wrong, it certainly wasn't their fault. If the project has progressed smoothly, discussions are entered

into much more enthusiastically. The individuals like to be recognized for their contributions, and the group as a whole appreciates *honest* praise for a job well done.

Probably the most popular group activity with both the men and the women has been the meals planned, prepared, and eaten in occupational therapy. Each group progressed from coffee, to coffee and cake, to simple breakfasts, to full meals. The menus they plan have not always been technically the best combinations of foods; basic nutritional facts are pointed out by the therapist and she helps set up some guidelines for planning, but the groups' satisfaction with the menus have seemed more therapeutic than a strict lesson in nutrition. Whenever possible, members of the group go with the therapist to the store and with guidance do the grocery shopping themselves. The men have needed a little more instruction than the ladies, but as a group worked more efficiently in the kitchen and prepared food that was as good as that prepared by the ladies. This surprised the men at first, but later became a source of pride.

There are several factors which help make cooking a good activity. The residents see this as a "normal" activity which they identify with the outside, and feeling that this is a special treat, show more willingness to participate than is usual with them. It creates some anxieties, especially among the ladies, some of whom have many doubts and conflicts concerning their role as homemakers. However, on the whole there is an atmosphere of relaxed or pleasant excitment which is very conducive to spontaneous conversations and total group interaction. The common goal enthusiastically shared creates more willingness to bring individual goals within the limits of the overall goal, or to give in if the two conflict. And of course, there is the very practical benefit of providing an opportunity to practice simple cooking skills.

Eating the meal with a small group in a family-type setting seems to create an awareness of table manners or perhaps the lack of them. The therapist eats at the table with the group and glaring errors are pointed out as they occur. The therapist tries to sit next to the person likely to need the most help with his manners in an effort to reduce his embarrassment as much as possible. Once they become aware of the need, most residents want to improve their manners and are willing to discuss ways of doing this in sessions following the meal.

One lady who was drinking coffee from her saucer and stuffing cake into her mouth with both hands, became quite hostile when told the correct way to drink coffee and eat cake. Later she said she "used to know how to do things right," but it had been so long since it mattered that she had forgotten. As a result of the ensuing discussion, the group decided to make their own etiquette handbook covering not only table manners, but practical, everyday manners.

From time to time the ladies have made decorative items, either as a group or individually, to give the Convalescent House a more home-like appearance. However, the outstanding project the men undertook fulfilled a much more basic need on their wing of the House. When this wing opened there were no night stands available; the men were told it would be some time before the hospital could provide them, so they decided to make their own. They measured the space available and planned them accordingly. One man who had worked in a furniture plant took the initiative in making a sample; the group approved it and they went into mass production. They even requested and obtained a consultation with the hospital paint foreman so that the paint for the stands could be mixed to match their wardrobes.

Pleased with the success of this project, they decided to make a few "extras", including an original design tile top coffee table, for which they made their own tile, bookcases, magazine stands, and ceramic ashtrays.

The bookcases were so admired by one of the Convalescent House social workers who was getting married that a joint committee of the men and the women decided to make one for her as a wedding gift. This was the first time the men and women had worked on the same project and there were doubts and negative feelings on both sides. The completed project turned out to be one of the nicest bookcases that had been made by any group in the occupational therapy woodshop, which was a source of great pride to both groups and produced increased mutual respect for each other's abilities. Later they undertook other cooperative projects, including flower gardening, jelly making, and the making of Christmas decorations. Surprisingly, the men, although reluctant at first, were generally as enthusiastic and creative as the ladies once they became involved in these activities.

Some of the activities planned specifically for improving everyday skills were handled as classes with instruction to the entire group followed by practice. Among the topics covered were clothing repair, manicures, package wrapping, using the can opener (the bottoms of empty cans were substituted for new cans), and using the telephone. The use of the telephone at first appeared to be one of the most threatening activities undertaken, but after proceeding very slowly and with much repetition, it became one of the more rewarding ones.

From time to time various problems arise, but the most frequently recurring difficulties have been those involved in helping the residents break their dependency patterns and develop initiative. At times it would have been much easier for the therapist to organize for the group than to see them tackle a task in a haphazard fashion or to simply do nothing toward accomplishing the task. There are times when it is necessary for the therapist to intervene, but with these residents particularly, it is important that such interventions be kept at an absolute minimum even though it may mean some projects turn out poorly. As previously mentioned, project failures are not wasted effort if the residents can learn from them. The key seems to lie in the therapist's ability to be constantly aware of what is actually (not apparently) happening within the group and to use whatever situations arise as means of effecting improvement within the individuals.

There are some physical factors which apparently affect the groups. They seem to function best when there are about twelve group members working in an area just large enough to comfortably accommodate them. This number is large enough so that no one gets an uncomfortable amount of attention, but small enough so that no one can get lost in the crowd, and working near each other seems to give some security and group unity. There has also been noted a basic difference in the reaction of the male and the female groups. It has been more difficult to provide activities of general interest to the men, but once their interest has been aroused, they have shown more esprit de corps than the ladies.

That there has been a marked improvement in many of the residents on this program has been obvious, but it would be quite difficult to determine to what extent the occupational therapy program has been responsible. It has been generally accepted that occupational therapy has played a vital role in

the overall Convalescent House program, especially in the early days when its resources were more limited than they now are. However, its main value has been, not in the fact that is has been a separate program, but in the fact that it has been an integral part of a much larger program with other disciplines all working toward common, clearly defined goals. An occupational therapy program utilizing similar principles, techniques and activities, but conducted independently, probably would have had some value, but it is doubtful that it could have been really effective without the kind of support and cooperation the program has had.

THE QUIET SEXUAL REVOLUTION

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The reaction to the sexual revolution discussed in the next few pages is quiet in comparison to the din produced by the revolutionary movement which is rapidly changing Western man's concept of sexual morality. I will leave the description of our new sexual ways and their propriety or impropriety to the defenders of our culture. Even though attitudes toward sexual activities change with time, the actual behaviors remain unchanged and it is the biological basis for these behaviors that we will examine. A number of discoveries in the past few years clarify the developmental background of sexual behavior and indicate that adult sexual activities may have their origin in the prenatal period.

For many years the development of sexuality was thought to coincide with the out-pouring of sex hormones during early adolescence. The picture was as follows. If an ovum received an X-containing sperm at conception, the individual developed with an XX complement of chromosomes. As development progressed the pituitary gland became active causing increased ovarian activity in such individuals which, in turn, produced a host of secondary sexual changes resulting in an adult female. In the case of males, the ovum was fertilized by a Y-bearing sperm and thus the testes responded to pituitary activity at puberty to produce an adult male. Two observations did not fit in well with this scheme, however. The first was that, even though genetic sex is established at conception, anatomical sex is not evident upon inspection of early embryonic stages because the precursors to both the male system, Wolffian ducts, and the female system, Mullerian ducts, exist side by side. The embryonic precursor to the gonads, the genital ridge, similarly remains an undifferentiated mass until, through an unknown message from the XX or XY chromosome arrangement, sex is declared and either the cortex of the genital ridge develops into an ovary or its medullary portion develops into a testis. The

second incongruous observation was that high levels of testicular activity are found in males at a well defined period of early development: prenatally in some species and in the early postnatal period in others. Until quite recently the importance of this period of hormonal activity was unknown. The discovery of its functional significance constitutes a revolution in our thinking about the origins of psychosexual orientation.

The first series of experiments that provide us with some insight into the significance of the early period of hormonal activity was conducted by Pfeiffer (1). Pfeiffer knew that female cyclicity is not a phenomenon that begins at embryonic sexual differentiation. Not until puberty do we see the onset of cyclicity: hesitant at first and more regular and predictable as adulthood is reached. Pfeiffer basically wanted to determine when this cyclicity becomes established; at puberty or before? Using newborn rats, he transplanted testes into either intact or ovariectomized females and ovaries into intact or castrated males. Upon examination of the adult rats with various transplants, he was able to conclude that ovaries transplanted into males castrated at birth ovulated at regular intervals and displayed cyclic changes in their hormone production, whereas ovaries transplanted to non-castrated males failed to cycle. Regardless of genetic sex, if a testis was present immediately after birth, cyclicity failed to develop and, in the absence of a testis, characteristic cyclity appeared, even in genetic males. Pfeiffer believed that the presence or absence of neonatal testosterone from the normal or the implanted testis acted on the pituitary to induce permanent acyclicity. In the 1930's, when Pfeiffer did his work, the control exerted by the hypothalamus over the pituitary was undiscovered and we must now modify his conclusion to state that the suppression of cyclicity is caused by testosterone acting on the hypothalamus rather than on the pituitary (2). Pfeiffer's work provided the first evidence that the neonatal hormone activity was important for the development of sexuality. For unknown reasons his findings attracted little attention and lay dormant until late in the 1950's when two laboratories reinvestigated the functions of neonatal hormones. These more recent studies were done by Harris and Levine (3,4,5) in England and Young, Goy and co-workers (6,7) in the United States. This research is of particular interest because the studies were methodologically more sophisticated (due to advances made in reproductive endocrinology in the intervening years) and because behavioral characteristics were measured as

a function of early hormone treatment in addition to simply measuring endocrine cyclicity.

Initially the behavior of adult guinea pigs and rats was studied as influenced by early injections of androgens and estrogens. The choice of guinea pigs and rats was deliberate because the former has a prolonged gestation and produces precocial (independent) young whereas rats have a short gestation period and produce altricial (dependent) young. Similarly, in guinea pigs the period of early hormone activity occurs prenatally, while in rats the period is immediately after birth. Adult female guinea pigs that had been treated with androgens during their prenatal period or female rats similarly treated immediately after birth were not only acyclic, as Pfeiffer had shown, but displayed masculine patterns of behavior in mating tests. Thus, it is evident that psychosexual differentiation became established by the presence of testosterone during a limited period of early development. A single dose of testosterone given to female rat pups within five days of birth is adequate to produce adults with an acyclic brain and a propensity for masculine behavior. The gonads themselves were not affected by the testosterone injection because an ovary from a treated animal transplanted to a normal adult female shows normal cyclicity and is able to maintain female behavior patterns. Similar transplant experiments with the pituitary also rule out this organ as the site of androgen action. All evidence points to the brain centers which control the cyclic release of gonadotropins and sexual behavior as being the site of action of the early androgen. These brain centers become masculinized in normal males by the presence of androgen during a critical period of development. In females, these centers can be artificially masculinized by injecting small quantities of testosterone at the critical period. That these brain centers are basically feminine regardless of the genetic sex of the individual was proven when castration of newborn male rats resulted in individuals which showed a cyclic pituitary and which would show feminine sexual behavior when given the proper female hormones during adulthood.

The above series of experiments on rodents forces a reexamination of our concepts of the biological basis of sexuality. Rather than the pituitary-gonad axis, the brain, and primarily the hypothalamus which contains the important sex centers must now be thought of as the control center for sex. Furthermore, regardless of the presence or absence of an XY chromosome complement, mammalian brains are basically female in terms of reproductive

cyclicity and behavioral propensity. Masculinity is the result of fetal androgens converting this "female" brain to a male brain during a few critical days of development. This is not to say that the chromosomal mechanism for the inheritance of sex has been dethroned. The XX and XY chromosome arrangement is the basic determiner of sex. However, the psychosexual orientation of the brain is not a consequence of neurones having an XX or XY chromosome complement. Rather, these neurones are bipotential and, whether they are organized along masculine or feminine patterns, depends on the presence or absence of testosterone during a short critical period of development. Under normal conditions, of course, the availability of testosterone is a consequence of the chromosomal complement which results in the presence or absence of a testis in the developing organism.

In the few years since these quiet, but revolutionary discoveries were made with rodents, a program has been underway to determine if such a sensitive period for androgens also occurs during non-human primate development (7). Extension of the rodent findings to monkeys would be important to show that the organizational ability of androgen in determining neural sexuality may be a general phenomenon in mammals, including man.

Using monkeys as experimental subjects presents a few difficulties not encountered when rats are employed. As in guinea pigs, the gestation period of primates is proportionately longer than in the rat and thus the time androgens are normally secreted during development falls during gestation. It is therefore likely that the sensitive period for neonatal androgens occurs prior to birth. Also, the monkey develops slower and one must wait years instead of months to find out whether prenatal hormone imbalance has produced an effect on adult behavior.

Fortunately this second difficulty can be somewhat circumvented because monkeys display behavioral differences early in life that are related to sex. Juvenile males, for instance, score reliably higher than females on such measurers as rough and tumble play, initiation of play, and threat behavior (8). This finding, which was incidental to studies conducted by Harlow and his co-workers, was capitalized upon by Goy (7,9). Goy and his collaborators first repeated Harlow's behavioral study to verify that reliable differences between the sexes were present in the behavior of young monkeys. Once that was confirmed the effect of castration immediately after birth on these behaviors

was tested with the result that castrate males, as juveniles, were behaviorally indistinguishable from the intact juvenile males. These results made it then necessary to determine whether hormone fluctuations prior to birth could effect these sex-related behaviors. Classic studies in the embryology of rhesus monkeys had pin-pointed the period of normal anatomical differentiation of the gonads to be from the 39th to 69th day of gestation (10). Hence, pregnant females were treated with testosterone during this period and the offspring produced by these females were studied. Genetic sex had to be identified by the chromatin test on buccal smears because the genitalia of treated females were markedly masculinized. Genetic females showed a well developed scrotum, no vaginal opening but a well developed phallus with a preputial orifice following prenatal exposure to testosterone. Two such females have been studied for four years (9). Each began regularly menstruating through their penises at the age of 2½ years, thus indicating the presence of an ovary, uterus, and deep vaginal vault. Regular menses were an unexpected finding and indicated that, unlike rodents, the basic feminine cyclicity was unaffected by prenatal androgen treatment.

The social behavior displayed by these females treated with testosterone *in utero* was intermediate between normal males and females during their first year of life but, beginning in their second year, they changed to show social behaviors which were indistinguishable from young male monkeys. As they matured they not only continued to show masculine social behaviors but they also displayed characteristic masculine sexual behavior. It is pertinent to note that even though the genetic females were showing masculine behavior their hormonal levels, as adults, were similar to normal females. Estrogen titers were within the normal range and no significant amount of testosterone was detected in their blood.

The conversion of genetic female monkeys to pseudo-hermaphrodites showing masculine behavior by androgenization during development indicates that the neural control of sexual behavior is organized prenatally in primates as well as rodents. The implications are strong that such prenatal organization of sexual behavior occurs in humans as well. In a preliminary report (9), human females exposed prenatally to androgens show "tomboy" characteristics as pre-schoolers. Whether such behavior will continue into maturity is as yet unknown. Additional instances of concordance between the animal data and various human

conditions have been reviewed by Money (11). Human female hermaphrodites showing the adrenogenital syndrome, i.e., virilized *in utero* from an excess of adrenal androgens, report having sexual experiences more typical of normal males than females. The perceptual components of erotic arousal are particularly reminiscent of the male in the sense that thresholds for erotic arousal are low for visual and narrative material. Another form of hermaphroditism, the testicular feminizing syndrome, may also provide a parallel. Such individuals are genetic males with a 46-XY chromosomal complement, and they progress through embryonic differentiation as males until the final stages of early development are reached and then, presumably because of a hormonal imbalance, the fetal testis fails to complete its normal development. As a result, feminine secondary sexual characteristics become manifest at puberty and the psychosexual orientation of such individuals as children and adults is feminine.

The animal studies further provide a model, if only a speculative one, for male homosexuality. Actions oriented toward the feminine end of the behavioral spectrum can be produced in rodents by either denying the developing male fetus testosterone at the appropriate stage or by injecting estrogen at a critical time. Such feminized males show the normal complement of male hormones in adulthood yet their behavior is decidedly feminine. Similarly, human male homosexuals, typically display normal male hormone levels after puberty and endocrine therapy has been largely unsuccessful in revising their displaced psychosexual orientation (12). As Dorner and Hinz (12) point out, it is not unlikely that prenatal endocrine disturbances underlies homosexuality, or at least some forms of this malady.

Although striking similarities exist between the experimental production of sexually anomalous animals and certain human conditions, it may be somewhat premature to transfer the animal findings to humans. There are two reasons for caution. First, inadequate experimental data is available to provide a complete picture of the role of early hormones on psychosexual differentiation in animals. This is especially true in the primate studies because the monkeys treated prenatally with testosterone are just reaching full adulthood at this writing. Secondly, social experiences during the postnatal development of humans are known to strongly influence gender role (13), regardless of chromosomal or physiological irregularities, and such experiences may override the organizational influences of prenatal

hormones. At any rate, the quiet revolution in our concepts of the physiological basis of sexuality bears close watching because, if verified, it provides us with evidence to show that fetal hormones act as organizers of sex in the developing brain, as well as indicating that heretofore unexplained abnormalities in adult behavior may have their origin in the prenatal period.

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CAN PUBLIC MENTAL HOSPITALS MEET THE COMPETITION?

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Abstract: This paper discusses various alternatives available to public mental hospitals confronted with changes in their traditional role. The material is presented in the context of a consultant's report to a company regarding future plans to meet increasing competition. The paper concludes that public mental hospitals should respond to the changing needs of their public and accordingly modify their function and organizational structure.

Introduction: Since the opening of the first asylum, there has been considerable discussion, both pro and con, about the role of the public mental hospital. Even ten years ago the liquidation of mental hospitals was advised by Harry Solomon who said, "I do not see how any reasonably objective view of our mental hospitals today can fail to conclude that they are bankrupt beyond remedy."[1] Although public mental hospitals as now known may continue their existence for some time to come, the question of their obsolescence is legitimate. For many years public mental hospitals have provided the only programs for mental patients. At present, however, new alternative types of treatment are increasingly available. In business terms, the public mental hospital industry is feeling the pressure of competition.

Can Public Mental Hospitals Meet the Competition? Similar reasoning could be applied to railroads, baseball attendance, psychoanalysis, etc. The chief executive of a business (or public mental hospital) might want to consider alternatives available when facing competition. He might retain a consultant to assess the present position of the company regarding future plans to meet increasing competition. Rather than pointing to a specific plan, the consultant might list the following alternatives for management's consideration.

Liquidate Assets: Your operation could be closed out. This would inconvenience established customers, but presumably

they would find new suppliers among your various competitors. Some financial return could be realized on the sale of capital assets; however, top management, unfortunately, might be charged with mismanagement. Your present staff would probably protest liquidation more than anyone else.

Sell: This would offer a greater return on capital assets as some other public or private organization might wish to continue a similar operation, or companies might adopt your plant to their production.

Invest in Other Operations: Continuing a skeleton operation would reduce the present operating loss but would avoid capital loss. Funds and personnel could be invested in or contracted to a competitor who enjoys a higher profit margin.

Deny: Your company could delay consideration of obsolescence and continue its present operation. This could result in eventual forced liquidation by creditors.

Fight: Such a cause could motivate and unite present staff. Discrete communication of competitors' problems to customers might put your operation in a more favorable light. This course might seem to offer the best chance for your organization to maintain its present state on a short-term basis. Before making this choice you should assess realistically your competitors' strengths and consumers' satisfaction.

Create Market: Without changing the basic organization, you might create a market by persuasive and positive advertising. Some change in package design would enhance consumer appeal. It should be noted that a good product is the basis of good advertising.

Achieve a More Competitive Position: This alternative would produce increased stress for the organization, but would not require a major change of direction. It could be achieved in one of two ways. You could aim for increased efficiency and economy (fewer employees, lower maintenance cost, greater productivity, etc.) or institute production changes to produce a more appealing and useful product. The latter might call for additional expenditures at a time when funds are in short supply.

Relocate: Although the transfer and relocation would be costly, you might be able to move into a market area which presently is not covered by competitors. The advisability of this step would depend to some extent on accurate forecasting

of competitors' strategy regarding expansion. Cost makes this a doubtful alternative. Also, competitors are in many cases already located closer to the market.

Recapitalize: This course of action presents obvious difficulties (raising funds in a tight money market and with questionable collateral) but would enable you to redesign the product, achieve a much more competitive position, and maintain the basic autonomy of your organization. Such a decision would involve some risk, as failure to float a bond issue would further decrease confidence and might even influence investors toward competitors.

Increase Price: The wisdom of this in a competitive market is doubtful. The Board of Directors might well reject this as they have so often in the past. If the initial (but substantial) resistances to a price increase could be overcome, it would offer many of the advantages of recapitalization with fewer risks. Past history suggests that a price increase sufficient to solve the problem is not feasible.

Change Product: This alternative is little different from selling out except that the present management would retain control. Admittedly, management would have to contend with the problems of switching into a new line; however, continued improvement of products and processes is generally considered a major responsibility of good management.

Reorganize: Change involves problems of reorientation, organizational stress, and effective planning (with establishment of goals, priorities, and evaluation and control procedures). It is also most helpful to forecast accurately the changing needs of customers. This alternative would offer the best opportunity so far of meeting competitors on a more equal footing while retaining autonomy. If properly handled, it can be a motivational factor with most employees. Some employees, however, may not be able to handle this stress or function effectively and you should be prepared for their resignation or termination. In terms of reorganizing to handle shifts in market and consumer demands, techniques already employed by competitors should be considered.

Acquire: Such a plan would require adroit use of secrecy, power, influence, and persuasion. The capacity of leadership to direct and coordinate a larger operation would have to be demonstrated as well as showing the desirability of the company

handling the major share of the market. This move would establish the organization in a controlling position, at least for the immediate future. The responsibilities of this action would be considerable and would be most demanding of the present management. It is only fair to say that competitors might well choose a similar course.

Merge: Joining forces with rivals would no doubt change some phases of the present operation and particularly would require that tasks be assigned to the most effective subsidiary, regardless of tradition. This would offer mutual exchange of personnel and ideas. Not the least would be the ability to tailor products more closely to customer needs. Assuming that suitable representation on the new Board of Directors is attained and that you are willing to accept a critical appraisal of the present company policy, this course would present the best opportunity for both your organization and that of major competitors. After joining forces, negotiations with allied but not directly competing firms could be considered with regard to a still broader market.

All this is not to overlook some significant problem areas. You would lose autonomy, face a drastic overhaul of your operation, and, no doubt, encounter some staff resistance and apprehension.

Nationalize: For some years you have been engaged in competition with other companies for funds, personnel, and markets. The public is now concerned about costs and consumer rights. You will probably have to accept the fact that all potential consumers must be served, rather than just those groups that are more profitable and who fit existing service patterns. Not only must you deal with the question of obsolescence, you and your competitors must consider consumer needs or face the possibility that external controls will be applied.

Discussion: Looking at the preceding alternatives, it is probable that public mental hospitals have tried them all with differing degrees of success. Even so, why have public mental hospitals been accused for so long of not meeting the needs of people? Inadequate resources is the easiest answer, but how well have we done with available resources? What brought on the Fourth Revolution in psychiatry and will there be inevitably a Fifth, Sixth, etc.?

It is doubtful that public mental hospitals can compete with alternative programs on the basis of being the sole treatment resource. Rather, they should be viewed as one component of a total system of care. An institution can participate in the develop-

ment of such a comprehensive program or it can be relegated to a minor and diminishing role. The deciding factor in this choice may be in the attitude of the chief executive officer. If his major goal is building and maintaining the present organization, he may find too late that the organization no longer has a role. If, on the other hand, his goal is providing the kinds of services that people need, his organization may find new roles. Public mental hospitals should be responsive to both the intra and extra institutional environment.

Summary: The obsolescence of public mental hospitals is a possibility that should be considered by their administrators and alternatives available to an organization considering this question have been presented. Although the goal of a public mental hospital should be meeting the needs of people, it is sometimes displaced to the goal of maintaining the organization. Public mental hospitals should respond to the changing needs of their public and accordingly modify their function and organizational structure.

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PSYCHIATRIC INPATIENT OR OUTPATIENT SERVICE— CHOICE BY AGE, SEX AND RACE

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The North Carolina Tri-County Psychiatric Patient—Population Project* was established to investigate by a central data collecting method utilization rates of psychiatric services of persons in Durham, Orange, and Wake counties. This case register collects data on patients from all psychiatric facilities serving this three county area, forming a data bank from which approaches to psychiatric epidemiology, particularly longitudinal studies of patient populations, are made possible. Administratively, program planning and evaluation can be aided by this type of patient population research. In addition to identifying items, demographic, clinical and socioeconomic data are collected. Herein is an analysis and interpretation of some active caseload data collected initially.

Active caseloads in psychiatric outpatient clinics and inpatients of state mental hospitals serving these three counties are the subject of this paper. Associations were sought among age, sex, race groups and choice of in or outpatient service.

Population

On July 1, 1964, there were approximately 351,000 residents in these three counties; 819 were inpatients in state mental

*This project is supported by U. S. Public Health Service Grant No. MH 01297-03.

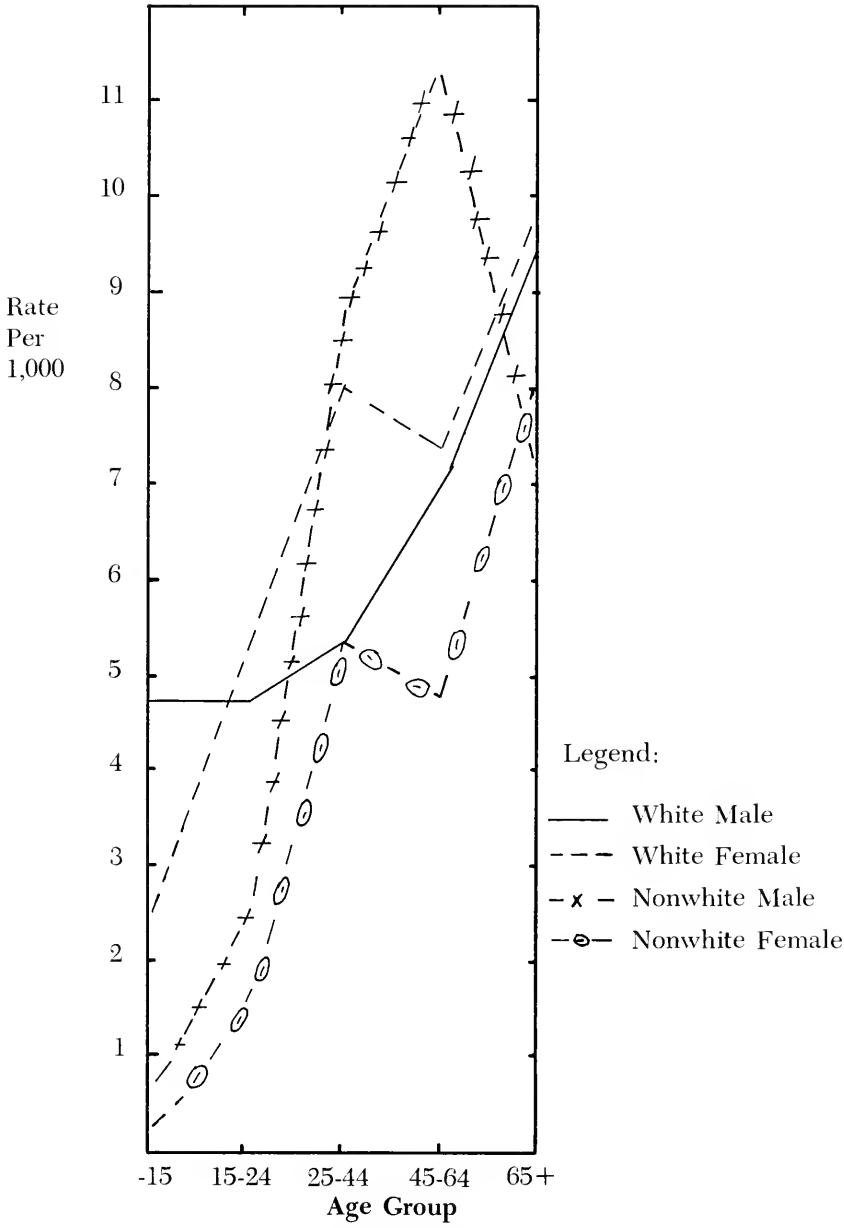


FIGURE 1. Rates of Patients in State Mental Hospitals and Outpatient Psychiatric Clinics (Combined) per 1,000 population by Age Group, Race and Sex, from Tri-County Area, June 30, 1964, North Carolina

hospitals and 1,048 were active cases°° in psychiatric outpatient clinics. Computing rates per 1,000 general population (estimated July 1, 1964) for each age, race, and sex group is an indicator of prevalence for that day in these two types of service. This study excludes patients in private hospitals, residential centers for the mentally retarded, and patients of private psychiatrists or other physicians in private practice.

Prevalence

Figure 1 presents the sex-race rates of mentally ill patients in these three counties receiving service at either state mental hospitals or outpatient clinics. Nonwhite males age 45-64 had the highest rate (11.6) followed by white females age 65 and over (9.7). The "less than 15" age group in all the sex-race groups had the smallest rate.

The rates plotted in Figure 1 are derived from combining both inpatient (state mental hospital) and outpatient (psychiatric clinic) services. Table 1 presents the race-sex rates in each of these two types of service.

TABLE I

One day prevalence rate per 1,000 population for state mental hospital resident patients and outpatients in psychiatric clinics, from Orange, Durham, and Wake counties, by race and sex, by rank order, July 1, 1964, North Carolina

	(a) Resident State *Mental Hosp.*		(b) Outpatient *Psychiatric Cl.*	
	Rank	*Rate*	*Rank*	*Rate*
Nonwhite Male	(1)	4.17	(4)	.82
Nonwhite Female	(2)	2.22	(3)	.82
White Male	(3)	2.15	(2)	3.41
White Female	(4)	1.93	(1)	4.11

°°Active Cases: Includes only those patients who had been seen at one of the clinics since April 1, 1964 and the patient who had been seen earlier but had been given a later return appointment—such as a patient seen in February with a return appointment in August.

The rank order of the race-sex rates is reversed in these two services: The non-white male active case rate was highest in the state mental hospitals and lowest in the outpatient clinics. The white female rate was highest in the outpatient clinic and lowest in the state mental hospitals. In addition, white males and nonwhite females change their relative position. Since changes in rates between inpatient and outpatient services are presented among all ages of the race-sex groups, it might be well to see how these two services differ for selected age groups of the race-sex groups.

Figure 2 shows that older white males were more apt to be inpatients than younger white males, who were more likely to be outpatients. The "less than 15" white male rate was slightly over 0.1 for hospitals, increasing to 8.1 in the "65 and over" age group. Clinics have the highest rate of white males (4.7) in the "less than 15" age group declining to a low of 1.7 in "65 and over" —a drop of 3 per 1,000.

In figure 3, white females are shown to differ from white males in the following ways: The rate for clinics increased from 2.4 in the "less than 15" age group to 6.3 in the 25-44 age group, then declining to 1.4 in the "65 and over" age group—a drop of nearly 5 per 1,000. The inpatient rate for white females was similar to white males: a low rate of 0.3 in the "less than 15" age group rising to 8.3 in the "65 and over" age group. Note also, in Figure 3 the rates for both clinics and hospitals were approximately the same for the 45-64 age groups but continuing from there in opposite directions.

Figure 4 indicates that nonwhite males of all ages were not active in the outpatient services: This group was hospital prone. Rising from 0.6 in the "less than 15" age group to nearly 1.4 in the 15-24 age groups, the rate then dropped off to 0.4 in the 45-64 age group. No nonwhite male 65 or older was active in the clinics. Outside of the "less than 15" and "65 and over" age groups the nonwhite males had the highest rates of the 4 sex-race groups with the 45-64 ages being the highest (10.9). The biggest increase in rates, for the nonwhite males, was from 1.2 in the 15-24 age group to 7.7 in the 25-44 age group. This was an increase of slightly over 6 times the 15-24 age group rate.

Figure 5 shows nonwhite females, like nonwhite males, were apparently not very active in outpatient services. In the "less than 15" age group the rate was 0.3 per 1,000 climbing to 1.6

Figure 2—White Male

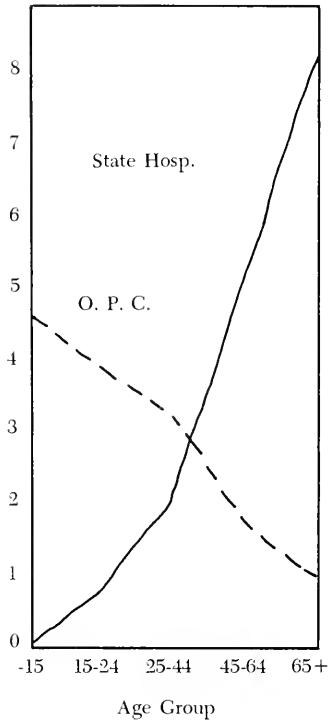
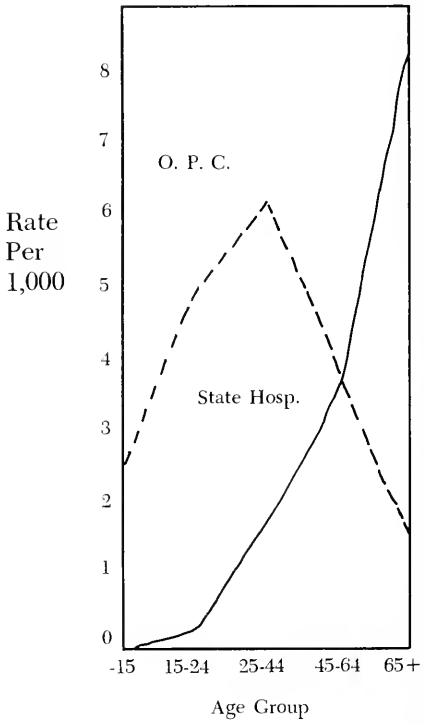


Figure 3—White Female



Comparison of Rates Per 1,000 Civil Population Between White Resident Patients in State Mental Hospitals and Outpatient Psychiatric Clinic Patients (Active Caseload) From Durham, Orange, and Wake County, By Sex, By Age Group, North Carolina, June 30, 1964

Figure 4—Nonwhite Male

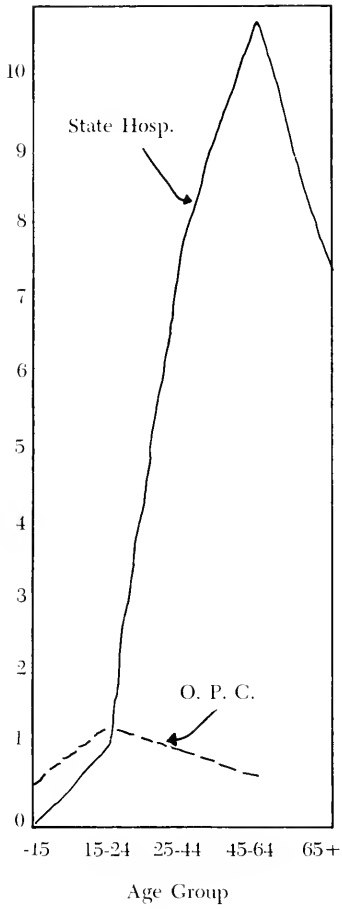
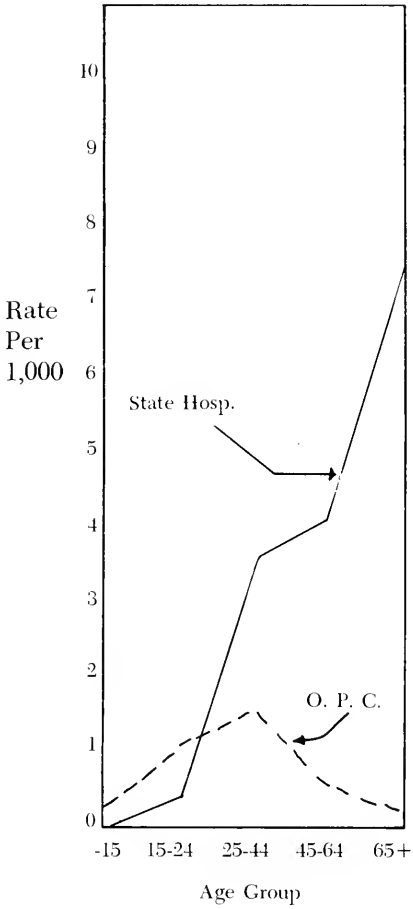


Figure 5—Nonwhite Female



Comparison of Rates per 1,000 Civil Population between Nonwhite Resident Patients in State Mental Hospitals and Outpatient Psychiatric Clinic Patients (Active Caseload) from Durham, Orange and Wake County, by Sex, by Age Group, North Carolina, June 30, 1964

in the 25-44 age group: The rate in the "65 and over" age group returns to the same as that in the "less than 15" age group (0.3 per 1,000). Also, like rates for the nonwhite males, the nonwhite female rates were highest in the hospitals. Starting with a rate of 0.6 in the "less than 15" age group the nonwhite female rate rose to 7.5 in the "65 and over" age group.

Analysis

These graphs and Table 1 suggest that an association existed between the various age groups and the four race and sex groups as to whether a psychiatric patient in one of these sub groups was more than likely either in a state mental hospital or active in psychiatric clinic than would occur by chance. Using the method described by Professor C. Horace Hamilton in his pamphlet "The Addition Theorem and Analysis of Variance in the Case of Correlated Nominal Variates"[3] in partitioning the various sources of variation and to test significance among the factors, the analysis of variance table is given below.

TABLE II

Analysis of Variance

Source of Variation	Sum of Squares	d.f.	Mean Square	F. Ratios
Age, Race & Sex (A B)	200.3	19	10.54	
Race & Sex (A)	46.23	3	15.41	110.07*
Age Group (B)	132.26	4	33.07	236.21*
Interaction (A B)	7.32	12	.61	4.36*
Correlation (A B)	14.49	12	1.21	8.64*
Error	259.43	1847	.14	
	459.73	1866		

*Significant at one percent level

[3]Contribution from the Rural Sociology Department, North Carolina Agricultural Experiment Station, Raleigh, North Carolina. Published with the approval of the Director of Research as Paper No. 1389 of the Journal Series. Revised Draft September 15, 1963

Are the associations suggested by the foregoing presentation of rates of utilization of certain in and outpatient services by sex-race and age-sex-race groups statistically significant?

In analysis of variance a significant difference occurred among the four sex-race groups in use of these two types of service; and a significant difference occurred among the five age groups and use of these two services. An interaction between this combined sex-race factor and age factor was shown to be significant. This interaction may be the result of one or more factors not measured in this study, lack of randomness, or change.[4] A significant correlation was found between sex-race and age.

Conclusion

Using a one day prevalence from two large psychiatric services to point up some patterns of utilization of two types of service of the mentally ill population in three counties (Durham, Orange and Wake), it is concluded that on July 1, 1964, the race-sex group in which a mentally ill patient belonged influenced the chances as to which service—inpatient state mental hospital or outpatient psychiatric service—he or she would go.

The age group in which the patient fell was also a deciding factor. These two factors, age and race-sex, were not operating independently of each other. Whites, both male and female, in the earlier age groups were more apt to be found in the clinics, but the older the patient, say 45 and over, the greater the chance he or she would be an inpatient in state mental hospital.

The nonwhite male or female did not utilize the service of the clinics to any great extent. Their rates were established mainly as inpatients in state mental hospitals.

DISCUSSION

Race-Sex

In the race-sex groups, the most striking finding is the utilization rate of the state mental hospitals and lack of use of outpatient

[4]Dixon-Massey, 1951. Introduction to Statistical Analysis. McGraw-Hill Book Company, Inc. Page 137.

clinics by nonwhite males measured by one-day prevalence. Suggestive ideas to approach an accounting of this have occurred in the minds of the authors: The nonwhite male is believed to be continually oppressed in the American culture generally, in the Southern culture particularly, and in his own ethnic group in addition. Emancipation enhanced this negative force as much as it began the way to freedom. Since emancipation there have existed elements of freedom which present demands rather than supports; increased expectations rather than gratifications; further subtle oppressions rather than means of expressing potential.

Therefore, the Negro male has the freedom to seek gainful employment outside slavery, but the opportunities for employment are few for him. The Negro has had freedom to seek training in technical skills, but no means within himself and his immediate culture to direct him to and provide him with the necessary training. When opportunities are exhausted, only limited resources are open to him in his family or his community to provide supplementary or intermediate care until opportunities return. In contrast, Negro females have as many job opportunities as Negro males, and even when opportunities are not available, they may have considerable family, community or government support. Thus, the Negro male has found himself since slavery in a world controlled by unfriendly men and in a family controlled by and favored women. With the necessary breakup of the family in the Negro culture very little continuing comfort, support and gratification is offered.

Moreover, the cultural habits derived over many generations of life in slavery and post-slavery oppression have become a strong built-in self-perpetuating system. One such habit is the Negro's disinclination through inability or unwillingness to use available helping resources. This disinclination may be partly the product of disguised inaccessibility which sometimes accompanies ostensibly available mental health services. Alternatively, or in addition, it may reflect a negative attitude among Negroes concerning direct pleas early in the course of need for help from community services, perhaps a manifestation of the syndrome of hostile dependence. The Southern Negro male, therefore, according to the training received through his family and culture does not ask for help until it becomes flagrantly obvious more often to others, that he needs it. Until July 1965, there was only one Negro state mental hospital in North Carolina, virtually the only inpatient psychiatric facility in the

state (outside Durham, Fayetteville and Salisbury VA hospitals). Compared to the other N. C. state mental hospitals generally, a higher proportion of admissions to this hospital are schizophrenic and a higher proportion are non-voluntary, suggesting the admission of sicker patients late in the disease.

Age

More young people less than 15 years of age (256 rate per 100,000) go to the clinics and few young people in this age group (7.0 rate per 100,000) go to the hospitals. Are young people really going, or are they being "taken?" In adult life the individual must identify his own problem and seek help whereas the child has his problem identified for him. The adult generally (and the male particularly) is reluctant, for both internal and external reasons, to admit problems of helplessness (mental or emotional illness). In this instance, like that of the nonwhite male, mental problems are not identified and help sought by those who have the problems; someone other than the person in need of help must activate the process of seeking solutions.

In most psychiatric outpatient facilities the service begins with the patient coming to the clinic and asking for help. Might it not be reasonable to extend this service into the population in order (1) to identify problems and (2) facilitate appropriate referral in addition to offering direct diagnostic and treatment service? This is hardly a new idea, but it is becoming an increasingly logical one, and one which this study supports.

Utilization of psychiatric services is studied in three North Carolina counties by the Case Register method. Analysis of one-day prevalence data from certain inpatient (state mental hospitals) and outpatient services (mental health clinics) reveal a high inpatient utilization by nonwhite males and high outpatient utilization of white females. Also, younger people had higher utilization rates of outpatient services, and with increasing age there was an increased use of the mental hospital. Education, cultural attitudes, and service accessibility are discussed as potentially important forces making utilization rates differ among various patient groups.

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THEORETICAL AND PRACTICAL ASPECTS OF FAMILY THERAPY FOR ALCOHOLISM*

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Conjoint, marital or family therapy for alcoholism has been recommended and used for over ten years. In spite of this, many treatment programs still focus all or nearly all of their attention upon the alcoholic himself, ignoring or even excluding significant other family members.

This paper will first review some of the data which give us a rationale for attempting a more total approach to the rehabilitation of the alcoholic whenever possible. Then, I will briefly review current knowledge and practice of such an approach.

Before specific observations were reported about the marriages and families of alcoholics, there were case reports of neurotic reciprocity being found in many couples in which one was a patient. In 1944, Mittleman[19] reported that improvement in one spouse was not always welcomed by the other and, indeed, adverse reactions could occur. He advocated serious consideration of the spouse in decisions to be made about psychoanalytic treatment.

Kohl[17] reported a study of 39 marital partners of patients receiving psychotherapy. Reactions to improvement in the identified patient included recurrence of alcoholism after prolonged abstinence, consideration of divorce, depression and anxiety, and negative reactions toward the therapist and the therapeutic process. Kohl stated: "A struggle for dominance between aggressively independent and passively dependent partners was found to be the most common dynamic factor in the treatment of complementary illness in marriage. Achievement of independence and the growing awareness and expression of resentment on the part of a passive patient commonly gave rise to a critical phase in treatment. Only when the spouse was prepared to accept as well as welcome resentment as a healthy sign of improvement was it possible to counteract his resistance to the patient's recovery."

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*Paper presented at 28th International Congress on Alcohol and Alcoholism, September 15-20, 1968, Washington, D. C., U.S.A.

It should be noted that Kohl exclusively studied marriage partners who had, or seemed to be having, adverse reactions of one kind or another to the treatment of the other partner. However, other studies do suggest that positive gains in the patient from therapy may affect other members of the family. For example, Fisher and Mendell[9] found that significant changes in the patient were accompanied by identifiable changes in other family members. They concluded that when one is treating a patient one is also treating the patient's family, whether there is explicit recognition of this point or not.

From his great experience in family therapy, Ackerman[1] has concluded: "The therapist influences family life not only during the therapeutic session, but also from afar, as a living presence in the emotional life of the patient and in his relations with other family members."

In a study of changes in family equilibrium during psychotherapy, Glasser[12] indentified three stages. The first was the stage of re-equilibrium following the patient's initial improvement, when the family assumed that old role models would be reestablished. A family crisis of disequilibrium occurred as the patient attempted new behavior patterns, and there was an emergence of a new equilibrium before termination of treatment. At the point of family disequilibrium, the patient's spouse often would need or seek help.

These studies were not specifically addressed to families with alcoholism. However, beginning in the 1950's, as therapeutic work with alcoholism increased, a variety of phenomena attracted the attention of therapists. One surprising discovery was that some wives had been married twice or more times to husbands with the problem of alcoholism. Closer scrutiny sometimes revealed that divorce had occurred following significant improvement in the alcoholism of a husband. Reports[11] [21] appeared in the early 1950's suggesting that the wives of alcoholic men might, in some instances, show specific personality characteristics. In 1956 Macdonald[18] reported a study of mental disorders in wives of alcoholics. Episodes of depression, for example, appeared when a significant period of sobriety had been achieved by the husband. Three years before that, Myerson[20] reported his discovery of the therapeutic advantage of interruping the dependency relationships in some alcoholic males.

In 1956 Fox[10] wrote at length about the alcoholic spouse, describing many of the typical marital interactions which appear.

The Alcoholics Anonymous family groups had already established themselves by this time. It is worth noting that many of the changes which may follow a wife's joining Alanon seem to be based on similar mechanisms to those promoted by the psychotherapeutic interventions described in this paper.

Almost 15 years ago, a group of colleagues and I[5] found that therapeutic work with alcoholic men, which resulted in periods of sobriety, was associated with punitive maneuvers on the part of the wives in many instances. Our realization that alcoholism occurs in a sick family unit, rather than an individual person, led to the establishment of concurrent group psychotherapy for the wives of men who were being seen in group therapy themselves. The majority of our experience has been with middle-class patients suffering from gamma-type alcoholism in the Jellinek[16] classification. We were forced to conclude that sometimes the husband's sobriety was a threat to the wife's emotional homeostasis. Supporting evidence included sabotaging attempts by the wife apparently aimed at promoting further drinking on the part of her husband, a variety of other resistances on the part of the wives, various reactions within the wives, such as depression, and instances in which the wife took up drinking herself. We were impressed by the fact that there seemed to be certain personality similarities among the wives of alcoholics and that concurrent changes had to be promoted within both marital partners before the man was able to maintain improvement. Those men in group therapy whose wives also entered group therapy remained in treatment for a longer period of time and showed significantly greater improvement on long-term follow-up when we evaluated drinking behavior and marital harmony.

In reviewing our experience with this technique we reported significant evidence of ambivalence within the men about the attendance of their wives. We also found that the wives tended to be very dominating toward a male therapist and that a more therapeutic orientation resulted from our introduction of a female co-therapist. The wives showed many individual and group defenses against seeing themselves as people requiring help. Awareness of their own, rather considerable, dependency needs was never very great and was often camouflaged by their caretaking role in relationship to the alcoholic husband, at least when he was drinking.

A natural continuation of the group plan of concurrent therapy has been to try to involve the wives of alcoholic males in treat-

ment whenever possible, whether in group or individual therapy.[6] However, there have been instances in which involvement of the alcoholic himself has been impossible. Under such circumstances, rather than regard the situation as hopeless, I[7] have experimented with "unilateral therapy" by involving the wife in brief counseling or group or individual psychotherapy. Beneficial effects from the point of view of the man's drinking pattern seem to depend upon having accomplished some change within the wife and within her relationship with her husband. Even some simple behavioral changes on the part of the wife can promote a favorable response. Sometimes the man's drinking behavior has seemed to represent mainly a hostile communication within the marriage. As soon as the wife was able to be less concerned, and to show her loss of concern over his drinking, a large part of the motivation for continued drinking seemed to have been lost. In virtually all of the successful cases involving psychotherapy with the wife alone, there has been a gradual awareness within her of the existence of dependency wishes which formerly had been largely kept at bay. She had to recognize the defensive nature of her relationship with her husband, her tendency to baby him and her strong need to rescue him and forgive him like a naughty child.

Whether in concurrent or unilateral therapy it is always important to introduce a therapeutic relationship to the wife very gradually. It often takes weeks or months for the wife to cease looking only at her husband's behavior and start wondering about her own.

Two major effects on the husband have seemed apparent with this treatment program. In the first place, many of the husbands became extremely curious about what was going on.

The second effect on the husband was to remove some of the unrealistic protectiveness with which the wife had often surrounded him. In this regard, unilateral therapy replicates the work reported by Myerson.[20] When the usual dependency relationships are partly withdrawn, the alcoholic man may now find it possible to face, and accept, his need for help with his drinking problem.

Even though the interpersonal and intra-psychic dynamics of the marital relationship have only begun to be studied and theorized about, it is clear that such therapeutic successes are highly congruent with what we already know about marriage, and in particular the marriage of the alcoholic. It should be

noted that Bowen[4] has reported therapeutic success of a similar nature in cases involving problems other than alcoholism.

My main experience has involved alcoholic men and their wives. It has been a rare thing to be able to involve family members to a significant extent in the case of alcoholic women and such marriages have not been studied in detail. Usually, the husband of an alcoholic woman has convenient social and business explanations with which to defend his inability to be involved in any continuing therapeutic engagement.

Some workers have tried to evaluate whether the personality of the alcoholic's wife represents a primary characteristic or a reaction to the repeated experiences and crises involved in being married to an alcoholic[15 2] This question will be answered by research studies of a prospective nature, but not by retrospective ones such as occur in the clinical setting. For the moment, the important finding is the seemingly improved results from joint therapy.

In another paper, I[8] have tried to examine these therapeutic results in the light of family relationships described by other workers. It is certainly possible to identify the interplay between husband and wife, when one has alcoholism, in terms of the "family rules" described by Jackson.[14] Similar light was shed upon the relationship by Berne[3] when he identified the "alcoholic game." One recent report which corroborates other work in family therapy of alcoholism is that of Griffith and his coworkers.[13] They sought to substitute a new "game" into the alcoholic marriage by involving the husband and wife in daily interactions around the use of disulfiram ("Antabuse"). As yet, they do not claim that this is more than a first-aid technique but the results are most impressive and suggest that the method should be tried in a variety of clinical settings by other workers.

Time does not permit detailed consideration of family members other than the spouse. Some programs offer needed counseling and help for other relatives of alcoholics. The Alateen organization has much beneficial support to lend to teenage children of alcoholic parents. It may be that further study will reveal that indirect benefits can accrue to the alcoholic sufferer from such approaches.

In conclusion, it is clear that much remains to be discovered about family and marriage psychodynamics, both with and without the complication of alcoholism. However, we already have enough clinical experience to validate the basic hypothesis

that alcoholism is dynamically related to the entire marriage and family. Thus, the involvement of the spouse in the therapeutic process, including attempts to promote personality readjustments within the spouse, is indicated whenever possible in planning a treatment program for the married alcoholic.

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DEVELOPMENTAL TASKS IN THE TRAINING OF A PSYCHIATRIST

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The person choosing psychiatry as a profession undergoes a series of emotional and intellectual tasks in his development as a psychiatrist. Although there has been considerable attention directed toward the training of psychiatrists in the more formal aspects of training (e.g. diagnostic and therapeutic skills),[1] [2]little has been written concerning these "developmental tasks." Apart from individual personality conflicts, which strongly determine how a person accomplishes any major task, there are conflicts inherent in the psychiatric training program itself, which must be resolved or "worked through" by the individual resident. This paper will define several of these tasks, briefly describe some of the conflict-areas which relate to them, and give examples of their manifestations in psychiatric residents.

An Acceptance of a "Learner's" Role

Halleck and Woods[3] have mentioned some of the conflicts which are inherent in the psychiatric resident's task of accepting a "learner's" role. In most psychiatric residency programs, the resident is initially placed on a ward where he is given responsibility for psychiatric patients. This is at a stage of his learning where his inexperience with psychiatric patients and unfamiliarity with psychodynamic principles make it difficult for him to assume these responsibilities. The conflicts presented by this situation are reinforced by the resident's repeated confrontation with other members of the staff such as nurses, social workers, psychologists, and attendants, who are already experienced in dealing with psychiatric patients. Even some patients, who are well-acquainted with psychiatric customs and terminology, threaten the resident's self-esteem because of his own "newness" and inexperience. Another factor contributing to these conflicts

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is the somewhat different role on the psychiatric service of "familiar" personnel. The resident in his medical training has learned to view the nurses and attendants as "administrators" of his orders, while the role of these staff members as "therapists" has usually been ignored or de-emphasized. In this new situation of training, however, he not only must adapt to a view of these personnel as adjunct therapists and important members of a treatment team, but he also must recognize that in many instances they can offer skills which he has yet to learn. In other words, to advance his knowledge he must be willing to learn from these and other "new" sources.

The conflicts arising in the acceptance of a "learner's" role by the beginning psychiatric resident, then, are influenced by the structural similarity of his role as a physician responsible for his patients to this same role in his previous medical experience. Instead of being a knowledgeable, competent authority in carrying out this role, he may be the least experienced member of the team. In trying to ward off feelings of inadequacy because of their limited psychiatric knowledge, some residents frequently over-rely on the more familiar diagnostic and treatment techniques ("the security of the somatic approach").[4] An example is the excessive use of medical and diagnostic tests in patient workups.

> A first-year resident was responsible for the treatment of a man with pain in his back, which not only caused him to be unable to work but also resulted in a complete "role-reversal" in his marriage, with the wife supporting the family and the patient keeping house. The man had been completely evaluated by a competent orthopedist prior to referral and transfer to the psychiatric service. Before discussing the patient with his supervisor, and instead of exploring the patient's conflicts and evaluating his family relationships, the resident delayed a number of days with repeated x-rays and consultation, although there was no evidence of organic damage. An anesthesiologist was requested to perform a "differential spinal" examination to "rule out the presence of psychogenic overlay."

Some residents react to these feelings of doubt and concern over their abilities in this new area of learning by over-dependence on and unrealistic expectations of psychological testing or social service casework. Frequently there may be an initial over-reliance on these tests, with requests for "psychologicals" on all patients indiscriminately, soon followed by complete

disillusionment with all such tests. This latter initially may be manifested by complaints of how little "concrete" information is in the reports, or how slow the reports of the tests are in returning.

> One resident in such a conflict was questioned about a patient who had been under his care for several days, and whose wife was contributing to and supporting his symtomatology. After explaining that he didn't understand the patient's difficulties, because the psychologist had not yet given his report, the resident remarked that he didn't know about the wife either, since he had not yet talked to the social worker.

Other residents may attempt to maintain feelings of adequacy by over-emphasizing their patient responsibilities to members of the ward staff, resulting in power struggles or mounting resentment between the resident and staff.

> One group of residents complained bitterly of the necessity of their writing requisitions for the laboratory studies which they had requested, although this was routine procedure on all services throughout the hospital. Their suggestion, furthermore, was that the nurses spend less time with the patients (considered by the residents to be the physicians' responsibility) and, thus, be free to write out the requisitions.

Other ways in which residents may attempt to cope with this concern over limitation of psychiatric knowledge is by missing supervisory hours or by "forgetting" to mention problem patients to supervisors. Or, as Sharaf and Levinson[5] and O'Conner[6] have emphasized, there may be a tendency to attribute "omnipotent" and "omniscient" qualities to senior members of the staff. While this may be an attempt on the part of the resident to reduce his own feelings of inadequacy, it may only delay the increasing of his abilities as he waits for some "miraculous" infusion of knowledge, and may lead to disillusionment when he is able to recognize the realistic limitations of his supervisor. Furthermore, his supervisor can rarely give the resident the security he seeks in undertaking this task, since the supervisor is a part of the structure which is contributing to the situation and often must function in its support as an administrator and evaluator, as well as a teacher.[3 7]

The Development of "Psychological-Mindedness"

A second major developmental task which is part of the structure of a psychiatric residency program is the development of

"psychological-mindedness." This is a rather vague, difficult-to-define term by which we mean the ability to understand the deeper motivations of human behavior, behind the usual defenses and rationalizations. "Psychological-mindedness" implies "an attitude of the mind. . . which is alert to the working of these deeper motivations. . . [and] pre-supposes an ability to empathize quickly and intuitively and to follow the emotional logic of behavior."[8] Again, as with the first major task, there are conflicting elements in the resident's training which make it difficult for him to accomplish this task without undue delay.

One factor which may contribute to this difficulty is the resident's tendency to identify in himself elements which are also evident in his patients. While this tendency is one which is shared with others who deal with psychiatric patients or study psychiatry, it often leads to the unsettling thought, "I must be 'sick', too" (i.e. incapable of helping these patients.) A resident struggling with this problem may attempt to protect himself by avoiding these patients, behavior which may lead to guilt and self-depreciating attitudes. There may be further doubts about his own ability in treating and diagnosing psychiatric patients, and his study and understanding of these areas will be delayed.

> A resident was experiencing difficulty in his psychotherapy with a graduate student who used intellectualization as a major defense. As his supervisor continued to point out his encouragement of the patient's defense, the resident began to be late for supervisory hours and be unprepared for his sessions. The supervisor, suspecting the cause of the resident's response, quickly pointed out that this reaction to such a patient was a difficulty not uncommon with beginning therapists and, moreover, that by attempting to understand the feelings eliciting this defense he could make better use of his reaction to the patient.

Some of the inherent difficulties in treating and diagnosing psychiatric patients may also cause frustration and disillusionment with psychiatric techniques and theories. In the resident's earlier medical training there were laboratory studies, EKGs, X-rays, etc. to give relatively quick validation of diagnostic hypotheses, while in the study of his psychiatric patients it may be weeks before he can validate diagnostic hypotheses, and even longer before his patients make substantial improvement. This is in contrast to the quick improvement he frequently saw in those patients he treated in his earlier training. If only his

unquestioning acceptance of psychiatrists has carried him through the early part of his training, it is almost certain that he will experience a period of disillusionment with psychiatric techniques and principles before he is able to be more realistic in his understanding of patients.

Residents who tend to make uncritical acceptance of theories based on the principles of "psychological-mindedness" frequently "over-interpret" to their patients. Deep analytical interpretations of childhood conflicts are made without regard to the patient's ego strength or readiness for such interpretations. The resultant failure in improvement of these patients may lead such residents to a complete rejection of these techniques and theories. Each patient is then seen as a candidate for somatic therapies or only the most superficial supportive care, the threat of losing self-esteem having caused the resident to reason, "It is not I who has failed, but the theory."

Another element contributing to the difficulty in developing "psychological-mindedness" is the depreciation and skepticism of psychological principles by many of the resident's medical colleagues. This may be manifested by subtle jokes at the luncheon table or open hostility over patient-centered discussions. It is an attitude which the resident may have encountered in his instructors in his medical school training, for first-year medical students are often more receptive to psychological principles than third or fourth year students. Other factors, such as the searching for simplified "cause and effect" relationships in patients' illnesses, which are difficult or impossible to demonstrate in psychiatric patients, may contribute to this depreciation of psychological principles by the resident's colleagues.

The skeptical and depreciating attitude of many of their medical colleagues toward psychiatric theories and techniques is especially difficult for residents to deal with in the early part of their training. They often feel committed to justify or "defend" their discipline; yet at the same time they are struggling with conflicting elements in their training which makes this even more difficult. In this situation, the resident may give more and more attention to medical detail. He may begin treating patients in situations where his medical colleagues are more expert, in an attempt to exhibit skills which his colleagues do not depreciate.

A first year resident was assigned to an elderly man who was admitted with depressive symptoms. Shortly after admission, the patient developed congestive heart failure. The resident

spent many hours examining electrocardiograms and adjusting the patient's Digitalis. Only after repeated suggestions by his supervisor did the resident request consultation from a cardiologist.

Athough the resident may be quite capable of handling such situations, his time would be spent more profitably in other areas.

The resident may react to this conflict in other ways, such as, for example, by becoming more isolated from his colleagues. Frequently residents struggling with this conflict develop a depreciatory attitude toward other specialists.

A second-year psychiatric resident was asked to evaluate a surgical patient who was exhibiting depressive symptoms. During his interview with the patient, the resident found that the patient was mildly diabetic, a fact the surgical intern had not discovered. The resident later generalized his experience, remarking in a devaluating way about surgeons, "who were such poor 'history-takers'."

By this defensive attitude, the resident may elevate his own self-esteem; but this attitude, if it persisted, would markedly limit his value as a consultant.

An Acceptance of One's Own Abilities and Limitations

Many of the conflicts which develop in the resident's attempts to understand his own limitations and to recognize his abilities can also be seen in his attempts to accomplish the two major tasks previously mentioned. Such problems as the resident's exaggerating his own successes or depreciating his therapeutic work, over-emphasizing the success of others at his own expense, over-reliance on others, or attributing to senior colleagues abilities and knowledge which they are incapable of possessing—these delay the successful accomplishment of this task.

There are other problems apparent in many residents, however, which also contribute to difficulty in these areas. For example, they frequently bring unrealistically optimistic ideas of the abilities of a psychiatrist into their training. In addition, pressure from patients, families of patients, and even staff members to "make" the patient improve their behavior feed into these "rescue fantasies." For the most part, the psychiatric patient is not the "acted upon" recipient of the doctor's skills, as is the surgical or medical patient. The psychiatric resident must accept the fact

that he is unable to "cure" the patient only by the power of his own skills or intellect. At this particular time in the resident's development, there may be increasing interest in game analysis and theory, where the goal seems to be to outwit the patient's illness and force him into health. The residents frequently grasp games theory as meaning that one can lever or manipulate people into health by clever maneuvers; affording, as it were, a certain amount of omnipotence for the resident himself. Also, the idea that its only "games people play" helps dispel the residents lowered esteem when his patients do not improve quickly. The fact that in many residency programs the resident is initially exposed to the most difficult to treat patients (e.g. hospitalized schizophrenic patients) may, on the other hand, lead to early and unnecessarily pessimistic attitudes toward his own therapeutic abilities. This again may be manifested by an overemphasis and over-reliance on somatic therapy techniques.

A first-year resident was treating a man with a high level of anxiety. The patient's life pattern revealed a history of forcing decisions on the part of those around him, which he could later attack as being unjust. He also tended to grasp at straws for relief of his anxiety. He demanded electroshock therapy from the resident who, between supervisory hours, agreed to order this treatment. The resident explained that he didn't feel he was helping the patient (who had been in the hospital only two weeks), so he wanted to give him a "trial" of EST.

Discussion

We have discussed some of the elements in the structure of a psychiatric residency program which produce conflicts for the residents. Of course, the individual resident's own personality determines, or at least modifies, the way in which he reacts to these conflicts. At times, exaggerated responses to these conflicts or unusual delay in progress in the resolution of these tasks may indicate the need for individual therapy. The frequency with which these problems arise in different resident groups, however, indicates to us that common elements of conflict exist in the training program. Authors from other training institutions[9, 10, 3, 11, 7, 4, 5] have mentioned some of these, primarily as related to the teaching and learning of psychotherapy. We feel, however, that there is value in identifying these elements as they appear more broadly in the training of psychiatrists. We believe that the primary value of conceptualizing these conflictual

elements and defensive manuevers in the framework of tasks which all residents must accomplish lies in its promoting a better understanding of and use of phenomena which are observed in residency training. The use of many of the defensive maneuvers which we have mentioned is often pointed to by administrators and supervisors as evidence of a "sick," and "immature," or just a bad resident. Yet it seems to us more useful to consider many of the defensive maneuvers as coping mechanisms which are likely to, indeed, should be expected to, arise as a result of elements in the training program itself rather than evidence of emotional problems which the "resident should work out in personal therapy."[9] The danger in abusing this latter approach, as pointed out by Schlessinger[4] is further damage to the resident's self-esteem and overwhelming of his coping mechanisms, leading to levels of anxiety which interfere further with learning. Use of the task-conflict-defense conceptual framework in training or supervising residents is more in line with the approaches advocated by Tarachow[12] or Searles[13] in supervision of psychotherapy in which the defenses (or counter-transferences) are by-passed and attention is directed to the problem of the conflictual elements. This approach is less likely to result in alienation of the resident from the supervisor, for the resident's self-esteem is maintained and, we believe, growth and learning are facilitated.

Abstract

In their development as psychiatrists, residents are confronted with common elements of conflict which are inherent in psychiatric training. This paper presents these conflictual elements in the framework of tasks which each resident must "work through" as he grows and matures as a psychiatrist. Three such "developmental" tasks are discussed: The acceptance of a "learner's" role, the development of "psychological-mindedness," and the acceptance of one's own abilities and limitations. Behavior seen in residents who are attempting to cope with these tasks is described. Examples such as avoiding patients, over-reliance on the more somatic diagnostic techniques and treatment, power struggles with ward staff, over-reliance on others, self-depreciation, and over-involvement with patients are seen as coping mechanisms common to residents who are attempting to deal with these developmental tasks. Recognition of these defensive maneuvers and anticipation of their development by supervisors and administrators will facilitate the residents' emotional growth and learning.

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MENTAL HEALTH RESEARCH ABSTRACTS

On May 24, 1968, a statewide research meeting was held at Dorothea Dix Hospital in Raleigh. Twelve investigators associated with the North Carolina Department of Mental Health presented 20-minute talks on their research, abstracts of which are below. The meeting was chaired by Peter N. Witt, M.D., Director of the Research Division of the North Carolina Department of Mental Health.

Gilbert Gottlieb
Abstracts Chairman

PERPETUATING FACTORS IN NEUROTIC BEHAVIOR

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It is suggested that a distinction be made between the originating and the perpetuating variables related to alcoholism. Efforts to effect change in the course of the disorder, once established, by focusing on etiological conditions have been notably unsuccessful. Four general areas of perpetuating variables may be identified with consistency in the most common types of alcoholism in the United States: physiological, social, economic, and psychological. It is hypothesized that these conditions may be markedly different from those that were present at the onset of the disorder. It is also hypothesized that these conditions are both aggravated by the excessive use of alcohol and at the same time the consequences of these conditions, in terms of generalized dysphoria of the patient, are relieved by the effect of the presence of alcohol in the patient's body. Psychological perpetuating variables related to this self-perpetuating and progressive process include anxiety, hostility toward authority, ambivalence toward dependency, paranoid concern, schizoid withdrawal, depression related to a sense of hopelessness and worthlessness, and excessive guilt.

Measures of the psychological variables are being employed as a means of testing these hypotheses using non-drinking, non alcoholics; drinking, non-alcoholics; drinking or active alcoholics and non-drinking or recovered alcoholics.

These measures will include: Minnesota Multiphasic Personality Inventory, Stern Activities Index, Moser Guilt Scale, and possibly some projective tests if adequately objective means of response measurement can be applied. Although this study will focus primarily on psychological considerations, some data relevant to the other three major categories of perpetuating variables will be gathered. We hope to obtain a brief medical history, a social history, and a review of economic factors at least over the period of the person's working life.

These measures should provide some information relevant to possible differences between etiological and perpetuating conditions. They should also provide data relevant to the hypothesis regarding the perpetuation and exacerbation of the disorder. If it is found that these perpetuating variables are present with greater frequency and severity as the disorder becomes more advanced, this could have an impact on both conceptual and treatment systems. If alcoholism as a process achieves a functional and circular autonomy from originating variables, then this should be reflected in our results.

Pilot project results using measures of anxiety with active alcoholics indicate anxiety levels significantly above the average for the general population and give encouragement to the pursuit of the more complete study to be developed during the coming year.

ON THE NATURE OF SELF–INJURIOUS BEHAVIOR

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This is the report of a series of experiments conducted with a seventeen-year-old girl and nine-year-old boy whose behavior has been largely limited to various forms of self-injury. Both

lack expressive language, function as mentally retarded, display psychotic features, and are virtually blind. Interest in these patients was stimulated by the work of Lovaas who has demonstrated effective control of self-injurious behavior through aversive stimulation and withdrawal of social reinforcement.

Experimental studies reveal the occurrence of self-injury in a variety of affective states including pleasant ones. Here, however, the behavior is non-injurious in intensity. The rate and intensity of the behavior tends to increase with agitation and may assume truly injurious proportions. Temporary response control has been achieved in the girl through limiting access to hard tactile stimulation, through social play, and through mild aversive stimulation (pinching). In the boy, response rate was lowered by ignoring it and by contingent withdrawal of physical contact. In order to try to completely eliminate the response and prevent the boy from further visual damage through self-hitting, painful but physically non-injurious shock was administered with a resultant dramatic reduction. Our observations confirm those of Lovaas including the apparent "acceptance" of shock as punishment. Finally, both patients appear to experience their behavior as aversive and to welcome restraint. They appear to be victims of a response which has negative as well as positive properties and over which they have only limited control.

DEPTH PERCEPTION OF SELECTED STIMULI IN RELATION TO PERSONALITY VARIABLES

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The purpose of this study is to extend knowledge of the personality-perception correlation. It was reasoned that if personality factors do influence perception, then individuals having similar personality dynamics should be influenced to perceive in similar ways. To test this, three groups were chosen which were believed to have different personality dynamics between groups but relatively similar dynamics within each group. The groups were then asked to perform on a task which was designed to set in motion the dynamics of one group while leaving the others unaffected.

The subjects used in this study were 72 males divided into three groups. Group I was comprised of patients from Broughton Hospital diagnosed as paranoid schizophrenic during a staffing attended by physicians, clinical psychologists, nurses, and psychiatric social workers. Group II consisted of penal inmates from the Morganton Branch of the State Prison. These subjects were described as similar to the diagnostic category of antisocial reation. Group III contained administrators and staff members from the North Carolina School for the Deaf and Western Carolina Center, a training school for the retarded.

The apparatus was a depth perception box. The subject's task was to line up two stimuli at the opposite end of the apparatus. The stimuli consisted of geometrical figures (circles and triangles) and photographs of human face profiles.

The hypotheses were as follow:

H_1 = As a result of the nature of the emotional disorder, paranoid schizophrenics should perform with more overall error in a depth perception task as compared to penal inmates and normals.

H_2 = Paranoid schizophrenics will demonstrate significant differences in stimulus alignment for certain stimulus combinations.

The results supported the first hypothesis, but the second had to be rejected in favor of the null hypothesis. Some unexpected differences were found, but their causes are unclear. It would seem that cues inherent in the stimuli may have aided in alignment more than was expected. Because of this it was impossible to determine the effects of the content of the stimuli on perception.

Group II consistently performed with less error than Group III (although the difference was not statistically significant.) This was not expected and points up the need for additional research in the area.

Recommendations for the improvement of the experimental design are as follows: (1) Those diagnosed as "paranoid" should be used as subjects rather than paranoid schizophrenics. (2) The stimulus objects should be changed in two ways: the content should be designed to bring more personality dynamics into overt expression; and, all of the stimuli should be the same size and shape.

PSYCHOPATHOLOGY AND THE EXPERIMENTAL ANALYSIS OF BEHAVIOR

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The purpose of this paper is to describe how the technique of experimental analysis can be applied to deviant or abnormal behavior and to compare this type of analysis to the more conventional statistical analysis.

The object of an experimental analysis is to establish a functional relationship between the probability of a response and an independent variable. Typically this is done by obtaining repeated measures of behavior from a single subject and then observing the effect of specific variables on the frequency of that behavior. The primary use of the technique has been to evaluate the behavioral effects of different parameters of reinforcement and punishment and for this purpose the most suitable dependent variable has been the rate of bar pressing by rats or disc pecking by pigeons.

Although the experimental analysis of behavior has become an established method of investigating basic behavioral processes, its application to the study of human behavior disorders has led to considerable controversy and resistance. It is generally argued that the multitude of basic functional relationships which have resulted from the use of experimental analysis have been obtained under highly controlled, artificial conditions with subhuman species and therefore are not relevant to the complex human behaviors displayed by the neurotic, psychotic or character disorders. The extent to which this is true can only be determined by conducting an experimental analysis of different types of deviant behavior. In this regard previous studies, though limited, suggest that the technique of experimental analysis offers some promise.

Following a more detailed discussion of this controversy, the relevance of this technique to the field of psychopathology

is demonstrated in a study involving the experimental analysis of cheating behavior. The S's in the study were institutionalized, mildly retarded adolescent boys displaying a high frequency of antisocial behavior. Each S was brought individually into a highly controlled laboratory setting in which he was confronted with repeated opportunities to cheat or violate the rules of the game. Because each S was used as his own control, only the data pertaining to two S's is presented. The first objective was to establish a frequency of cheating. As soon as the frequency of cheating had become stable, a variety of independent variables were introduced and evaluated by direct observation of their effect on the frequency of cheating response. The variables which were evaluated include the effects of an observer, punishment and increased task difficulty.

The experimental analysis of cheating is then compared with other investigations of cheating involving the more traditional statistical analysis. Finally it is pointed out that while there are aspects of psychopathology which do not lend themselves to an experimental analysis, the technique does yield very precise functional relationships between the behavioral and environmental variables when it can be applied.

THE TWO-TYPE THESIS OF DEPRESSIVE DISORDERS: AN MMPI DEPRESSIVE CATEGORY-TYPE SCALE

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Controversy still occurs regarding the existence of two-types of depressive disorders. In a previous report we described the structuring and standardization of an observer rating scale, the Depressive Category-Type Scale, which, on total scores, distributed depressive subjects bimodally into two distinct populations. In structuring and standardizing this scale considerable effort was directed at minimizing the effects of "rater bias", nevertheless, this was the major area of criticism of this device. The aim of the present study was to devise a subjective rating scale which would also divide depressions into two distinct populations.

Structuring the subjective rating scale: One hundred consecutive depressed patients, who were able to complete the MMPI, were classified into two groups according to their scores on the Depressive Category-Type Scale. Category-Type A depressions had scores of 26 or greater; Category-Type B depressions had scores of 25 or less. The 550 items of the MMPI were then scored individually to define items which had been answered significantly differently by these two populations. Chi squared values for each item were computed by machine. Twenty four MMPI items had Chi squared values of greater than 25. These items were listed on a form in random serial order. This new device was arbitrarily called the MMPI Depressive Category-Type Scale.

Validation: The observer and subjective Depressive Category-Type Scales were administered to a further population of 82 depressed patients. These tests were presented as part of a more comprehensive battery of behavioral and physiological tests, all of which were administered in the same sequential order. The observer ratings were completed before the subjective ones.

The results showed that the total scores on the MMPI Depressive Category-Type Scale were bimodally distributed. A Spearman Rank Coefficient of Correlation showed a significantly high positive association between the scores on the observer and subjective rating scales ($Rs.^{\circ}.483\ p<.001$). When the MMPI Depressive Category-Type Scale scores were dichotomized according to the equivalent scores on the observer scale two significantly different populations were produced. ($t=4.897$, 80df, $p<.001$)

DEVELOPMENT OF MOTOR PATTERNS IN CHICK EMBRYO

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Knowledge of the development of behavior in embryos has fallen far behind that of neonatal or adult behavior. Yet, for some of the more basic aspects of behavior, such as motor patterns, this period of time is probably quite important. Both for availability and technical ease the chick embryo is an ideal organism for such studies of "behavioral embryology".

Research to date has reached a number of interesting findings concerning behavior of the chick embryo.

1. Embryos are active (body movements) throughout most of the incubation period.
2. Many of these movements are independent of sensory instigation from the external environment.
3. All sensory modalities of the chick embryo are functional before hatching.
4. Movements of the chick embryo are dependent on spinal mechanisms and brain mechanisms.
5. The early movements of chick embryos have no obvious co-ordination or pattern (but see below). They appear convulsive-like.
6. A few days before hatching chick embryos begin to indulge in specific behavior patterns (motor coordination) which serve to get them into a proper posture for hatching and which serve to actually get them out of the egg.

Currently we have *no* information on what relationship, if any, there might be between prehatching (embryonic) motor patterns and posthatching behavior patterns. For example, are there embryonic precursors of pecking, walking, flying, etc.? Until behavioral scientists are able to answer such questions it is futile to argue about the degree to which a given adult behavior pattern is independent of prior experience or prior occurrence.

The laboratory of neuroembryology in the North Carolina Department of Mental Health is currently involved in studies to evaluate embryonic motor patterns and their relationship to neonatal or adult patterns.

INFANTILE CONTROL OF MATERNAL BEHAVIOR: A NEGLECTED PHENOMENON

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Most theories of personality development stress the influence of the parental environment in determining the personality char-

acteristics evinced by the infant in adulthood. Other than correlational studies or case histories, there is as yet no firm evidence to suggest that the adult personality of the infant is in fact molded by its parents. Further, the selective or active components of the infant's behavior have been disregarded, thereby perpetuating the assumption that the infant is essentially passive and waiting to be shaped by its environment ("blank slate" theory of behavioral development). Such a view is also perpetuated by certain theories of learning, particularly the stimulus-response and conditioning points of view, which seem to assume a passive organism regardless of age.

A cursory survey of the animal behavior literature shows that the infant's behavior governs the parental response during various stages of development in all species of mammals and non-human primates thus far studied. A very preliminary study of a single human infant (male) conducted by the author revealed that the infant initiated the large majority of the 86 mother-infant contacts which were observed during the second and third months of life.

It is to be hoped that in the future the active, striving, and controlling features of the human infant's behavior will come under scrutiny, thereby bringing a more balanced perspective to our attitudes about the causative factors of personality formation and, possibly, mental disorder in later life.

ENVIRONMENT, HORMONES AND BEHAVIOR

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A reexamination of two concepts concerning the relationship between hormones and behavior showed that behavioral states can strongly influence hormonal levels rather than the other-way-round and that hormones continue to play an important role in the expression of primate behavior.

Modifying the social environment present during the development of young mice results in a marked acceleration of their rate of sexual development. Female mice exposed to an adult male for twenty days either from birth or from weaning reach puberty when less than 40 days old. If, on the other hand, females are

denied the presence of a male during development their puberty is delayed until about 60 days of age. It thus seems apparent that the processes leading to sexual maturity are strongly subject to environmental influences and future research must now identify more accurately both the environmental conditions necessary for acceleration of maturation as well as the underlying neural mechanisms which are subject to such environmental modification.

The role played by hormones in initiating behavior is normally thought to be superceded by cortical functions in the higher mammals. Based on recent primate studies this concept may require considerable modification. Studies in England have shown that ovariectomy abolishes female receptivity in rhesus monkeys and that sexual behavior can be reinstated by administering estrogen. Once reinstated by estrogen, the sexual behavior can again be eliminated by another gonadal hormone, progesterone. Studies now in progress in Puerto Rico will attempt to extend these findings by asking whether the changes wrought by injected hormones can also be produced endogenously by modifying the environment.

THE MUCOPOLYSACCHARIDOSES

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There are seven clinical syndromes associated with increased acid mucopolysaccharide excretion in the urine: Hurler's, Hunter-'s, Sanfilippo's, Morquio's, Scheie's, Maratoux-Lemy's,[1]and the Murdoch syndromes.[2] The Murdoch syndrome consists of mental retardation, monkey-like facies, low hairline at the temples, psychotic behavior, and marked increase in urinary excretion of acid mucopolysaccharides. There are no visceral or radiographic manifestations such as seen in Hurler's syndrome. Those syndromes involving excretion of heparitin sulfate, alone or in combination with chrondroitin sulfate B, are associated with mental retardation and/or severe behavior disturbances.

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Electron microscopy and radioisotope studies indicate that these conditions involve a defect in the catabolism of acid mucopolysaccharides, and not an over-production. The mucopolysaccharides are normal in structure.

Attempting to alter the course of several of these conditions, we have utilized: ketogenic diet, pimitine hydrochloride (IN 379), vitamin A, and cortisone acetate. The first three procedures have had no apparent clinical or biochemical effect. We are presently experimenting with hyperbaric oxygen in conjunction with Dr. James B. Sidbury at Duke Medical Center. Tissue acid mucopolysaccharide levels were much lower in one patient with Hurler's syndrome treated with cortisone acetate than in a similar patient not treated (by a factor of 20).

Tissue studies have shown a decrease in arylsulfatase A and a rather marked increase in arylsulfatase B in Hurler's syndrome. In contrast, the arylsulfatase A is normal and arylsulfatase B is increased in the Murdoch syndrome. These studies are still in progress.

COMPUTER SIMULATION OF DECISION-MAKING USING MARKOV CHAINS

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Most studies of decision behavior, while clearly demonstrating the relationship between available information and decision outcomes, provide results which are static, that is, do not capture the drama or dynamic nature of the decision process. This is particularly true of statistical-empirical studies in which a still picture is given but nothing is known about the changes which occur in decision values as new information is acquired over time. To overcome such a limitation a synthetic model has been developed based on general empirical observations but with the intent of studying the decision behavior as it exists in reality—as a dynamic process.

The model proposed is probabilistic and subject to change over time as new information which reinforces or increases the value

of any decision alternative is put into the model. The model is based on the theory of markov chains in which the probabilities of selecting the decision alternatives is expressed as a vector and the probabilities of transferring from one alternative to the next ("changing one's mind) are a matrix.

Placing the model on a digital computer the behavior of the model under a variety of information input combinations can be observed. Through such computer simulation in which the model is expressed in formal, mathematical terms results have been obtained which closely match empirically-based observations as well as permitting the investigator to observe internal changes which produced such results. Important conclusions from the analysis are: (1) the earlier a decision-maker encounters information about a particular alternative, the more impact ("influence") this will have on the final decision; (2) the influence of any information input is related to the number of other similar inputs in close sequence; and (3) drastic changes in the process (representing extreme shifts in decisions preference) do not occur through the influence of one or two information inputs. Change is more gradual and orderly.

Notice to Contributors

Manuscripts and editorial comments should be addressed to the Editor-in-Chief, N. C. Department of Mental Health, P. O. Box 9494, Raleigh, N. C. 27603.

Contributors need not be psychiatrists, neurologists or M.D.'s but should be involved in some aspects of program, whether clinical, educational, or research, pertinent to mental health or mental illness.

Manuscripts offered for publication should be submitted in the original, typed on bond paper and double spaced with 70 characters per line. Footnotes, bibliographical references, quotations, etc., should also be double spaced and the use of footnotes minimized.

References to books and journals should be numbered consecutively in a bibliography at the end in the order in which they appear in the manuscript. References should be limited to those used by the author in the preparation of the article and kept to a minimum.

The author's privilege of correcting galley proofs may apply only to printer's errors.

Tabular material, drawings and charts should be submitted on separate sheets, clearly marked as to where they are to appear in the text.